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UNITED STATES BANKRUPTCY COURT
SOUTHERN DISTRICT OF NEW YORK

In re **LEXINGTON PRECISION CORP., et al.,** **Reorganized Debtors.**	**Chapter 11 Case No. 08-11153 (SCC)** **(Jointly Administered)**
TRUSTEE OF LEXINGTON PRECISION CORPORATION GROUP MEDICAL CARE PLAN **and** **LEXINGTON PRECISION CORPORATION** **Plaintiffs,** **v.** **CHAD MCGOWAN, ESQ., MCGOWAN HOOD & FELDER, LLC, AND JUSTIN E. PRESLEY** **Defendants.**	**Adv. Proc. No. 10-_____**

ADVERSARY COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF AND TURNOVER OF ESTATE PROPERTY

TO THE HONORABLE SHELLEY C. CHAPMAN,
UNITED STATES BANKRUPTCY JUDGE:

Lexington Precision Corporation ("**Lexington**") and Lexington Precision Corporation Group Medical Care Plan (the "**Plan**," and together with Lexington, "**Plaintiffs**"), as and for their adversary complaint against Chad McGowan, Esq. ("**McGowan**"), McGowan Hood & Felder LLC ("**McGowan Hood**"), and Justin E. Presley ("**Presley**") (collectively, "**Defendants**"), hereby allege as follows:

SUMMARY OF THIS ACTION

1. This action arises from Defendants' refusal to pay funds owed to the Plan and Defendants' knowing disregard of both their legal duties and title 11 of the United States Code (the "**Bankruptcy Code**") in order to gain leverage and personal reward at the expense of the Plan and Lexington's other creditors.

2. Despite repeated demands from Lexington (the Plan's administrator) and Lexington's counsel, Defendants have unilaterally withheld and continue to withhold $199,911.54 that Defendants admittedly owe to Plaintiffs for the reimbursement of medical expenses that Plaintiffs previously paid on behalf of Presley.

3. Accordingly, Plaintiffs bring this action to obtain: (a) the turnover of property of Lexington's chapter 11 estate wrongfully held by the Defendants pursuant to section 542 of the Bankruptcy Code; (b) a declaration establishing (i) the unlawfulness of Defendants' refusal to reimburse the Plan with the Subrogation Funds (defined below), and (ii) Plaintiffs' entitlement to reimbursement of the Subrogation Funds under ERISA's civil enforcement provision, 29 U.S.C. § 1132(a)(3); (c) an injunction directing immediate payment of the Subrogation Funds pursuant to 29 U.S.C. § 1132 (a)(3); (d) a

judgment finding Defendants McGowan and McGowan Hood tortiously interfered with the contractual relations of the Plan and Presley; (e) a judgment finding McGowan and McGowan Hood converted the Subrogation Funds in which they acknowledge the Plan has an interest; (f) a judgment finding that the Plan has a promissory estoppel claim against McGowan and McGowan Hood; and (g) imposition of a constructive trust in favor of Lexington as to the Subrogation Funds under ERISA's civil enforcement provision, 29 U.S.C. § 1132(a)(3).

JURISDICTION AND VENUE

4. This is a civil proceeding under 11 U.S.C. § 542 and 29 U.S.C. § 1132(a)(3), arising under title 11 and arising in a case under the Bankruptcy Code, within the meaning of 28 U.S.C. § 1334. It is properly brought as an adversary proceeding pursuant to Rule 7001 of the Federal Rules of Bankruptcy Procedure (the "**Bankruptcy Rules**").

5. This Court has jurisdiction to entertain the claims asserted herein pursuant to 28 U.S.C. §§ 157 and 1334. This is a core proceeding under 28 U.S.C. § 157(b)(2)(E). Venue is proper in this district under 28 U.S.C. § 1409(a).

6. This Court has personal jurisdiction over Defendants pursuant to Bankruptcy Rule 7004(f) and 29 U.S.C. § 1132.

THE PARTIES

7. On April 1, 2008, (the "**Commencement Date**"), Lexington commenced with this Court a voluntary case under chapter 11 of the Bankruptcy Code. Lexington's principal place of business is located at 800 Third Avenue, New York, New York, 10022.

8. Lexington is a reorganized debtor pursuant to a plan of reorganization confirmed by this Court.

9. McGowan Hood is a limited liability company with its principal place of business in South Carolina.

10. Upon information and belief, McGowan is an individual residing in South Carolina.

11. Upon information and belief, Presley is an individual residing in South Carolina.

FACTUAL ALLEGATIONS

A. The Contractual Relationship Between Presley and Lexington

12. Lexington employed Presley from June 22, 2005 to July 19, 2010.

13. Beginning in September 2005, Presley was a member under the terms of the Plan. He remained a member through July 19, 2010.

14. On September 10, 2007, Presley was involved in a motorcycle accident.

15. A third party tortfeasor was involved in the accident.

16. As a result of the accident, Presley sustained significant medical injuries.

17. As a member of the Plan, the medical expenses Presley incurred as a result of the accident were paid by the Plan.

18. The Plan paid a total of $199,911.54 in medical expenses for Presley (the "**Subrogation Funds**").

19. As stated in that certain Summary Plan Description for the Plan, a copy of which is attached hereto as **Exhibit A** (the "**Summary Plan Description**"), the Plan contained a subrogation provision stating, in part:

> This *Plan* reserves all rights of subrogation. This means that the *Plan* has the right to recover its previously paid benefit payments from any award, settlement, or damages that you or your *covered dependents* may receive or to which you may become entitled. It also means that the *Plan* has the right to assert your rights (take action on your behalf) to obtain an award, settlement, or damages.

Summary Plan Description at 25.

20. This subrogation clause entitled the Plan to full reimbursement and did not reduce any such reimbursement for attorney's fees and/or a pro-rata share of expenses.

21. Presley was aware of this subrogation provision certainly no later than September 2005.

22. Presley retained McGowan Hood as counsel in his lawsuit against the third party tortfeasor involved in the car accident.

23. McGowan Hood was also aware of the subrogation provision no later than March 2010.

B. The Settlement Amount

24. McGowan Hood secured a settlement (the "**Settlement**") for Presley in the amount of $1,250,000 (the "**Settlement Funds**").

25. McGowan Hood disbursed $500,000 of the Settlement Funds to itself as attorneys' fees.

26. On that certain Disbursement of Funds form used in allocating the proceeds from the Settlement, McGowan Hood listed the amount of $199,911.54 as a subrogation lien to which the Plan is entitled.

27. McGowan Hood requested, however, that the Plan reduce its lien to $150,000.

28. The Plan refused to reduce its lien below the contractually mandated amount to which it was entitled.

29. McGowan Hood then represented to the Plan and/or the Plan's claims administrator that McGowan Hood would hold $150,000 in trust until a court ruled on the Plan's entitlement to the full $199,911.54.

30. The $150,000 held in trust is the amount McGowan and McGowan Hood have offered as full settlement of the subrogation lien.

C. The Plan's Demand for the Subrogation Funds.

31. The Plan, through its counsel and claims administrator, has repeatedly asserted to McGowan and McGowan Hood its right to all of the Subrogation Funds.

32. McGowan Hood and McGowan have not disputed that they corresponded with the Plan's administrator, Lexington, or counsel for Lexington about the Plan's subrogation and reimbursement interest.

33. The Plan is a self-funded welfare benefit plan, the assets of which are property of Lexington's chapter 11 estate.

34. The Plan has requested that McGowan Hood and McGowan, at a minimum, release to the Plan at least the $150,000 in funds that McGowan Hood and McGowan concede is owed to the Plan under the subrogation provisions of the Plan.

35. McGowan Hood and McGowan refuse to release even the $150,000. McGowan Hood has represented to the Plan and/or the Plan's claims administrator and Plan's counsel that it will not release the $150,000 until Presley authorizes it to do so, and Presley has failed to authorize the release.

COUNT I

(Turnover Pursuant to Section 542 of the Bankruptcy Code)

36. Plaintiffs repeat and reallege each and every allegation set forth in paragraphs 1 through 35 as if fully set forth herein.

37. McGowan Hood is in possession of the Subrogation Funds, which funds are property of the Plan and, in turn, Lexington's estate and, therefore, are subject to turnover pursuant to section 542(a) of the Bankruptcy Code.

38. Section 542(a) of the Bankruptcy Code provides that:

> [A]n entity . . . in possession, custody, or control, during the case, of property that the trustee may use, sell, or lease under section 363 of this title, or that the debtor may exempt under section 522 of this title, shall deliver to the trustee, and account for, such property or the value of such property, unless such property is of inconsequential value or benefit to the estate.

39. Pursuant to section 542(a) of the Bankruptcy Code, Defendants are required to deliver the Subrogation Funds to Lexington, as the administrator of the Plan.

COUNT II

(Declaratory Judgment That Defendants Have Violated the Plan's Right to Reimbursement And An Injunction Directing Defendants To Immediately Pay To Plaintiffs, In Full, The Subrogation Funds And All Accrued Interest Thereon)

40. Plaintiffs repeat and reallege each and every allegation set forth in paragraphs 1 through 39 as if fully set forth herein.

41. Defendants are fully aware of the Plan's subrogation provisions.

42. Defendants have violated the terms of the Plan by refusing to turn over the Subrogation Funds.

43. To date, Defendants have failed to pay any portion of the Subrogation Funds.

44. Moreover, Defendants have stated their intention to seek restriction of the Plan's reimbursement rights to the full amount of the Subrogation Funds.

45. Pursuant to ERISA's civil enforcement provisions, 29 U.S.C. § 1132, Plaintiffs are authorized to bring suit to enjoin violations of an ERISA plan and obtain equitable relief to redress any such violation or to enforce the provisions of an ERISA plan. See id. § 1132(a)(3).

46. By virtue of the foregoing, there now exists an actual, justiciable controversy between Plaintiffs and Defendants relating to their respective legal rights, duties, and obligations under ERISA, which controversy is now ripe for adjudication pursuant to 28 U.S.C. § 2201.

47. Plaintiffs therefore request a judgment declaring the rights and obligations of the parties, including (i) a declaration that the refusal of Defendants to reimburse the Plan with the Subrogation Funds is an unlawful violation of the Plan; and

(ii) an injunction directing Defendants to immediately pay Plaintiffs, in full, the full amount of the Subrogation Funds – $199,911.45 – plus all accrued interest thereon, in accordance with the Plan's subrogation provisions.

COUNT III

(Defendants McGowan and McGowan Hood Have Tortiously Interfered with the Contractual Relations Between the Plan and Presley)

48. Plaintiffs repeat and reallege each and every allegation set forth in paragraphs 1 through 47 as if fully set forth herein.

49. There is a valid contract between Presley and the Plan.

50. The valid contract contains a subrogation clause providing that recovery in a third party action required Presley to repay, out of the recovery funds, the amount the Plan paid in medical expenses.

51. McGowan and McGowan Hood are aware (and have been aware since no later than March 2010) of the valid contract.

52. McGowan and McGowan Hood acknowledged the Plan's lien in writing and are holding $150,000 of the $199,911.94 Subrogation Funds in trust.

53. McGowan and McGowan Hood intentionally disbursed, to Presley, $49,911.45 of the $199,911.94 in Subrogation Funds.

54. McGowan and McGowan Hood have additionally refused to release, to the Plan, the $150,000 of the $199,911.94 that McGowan Hood is holding in trust.

55. McGowan and McGowan Hood intentionally and maliciously induced Presley to violate the valid contract by not releasing the Subrogation Funds to which the Plan is entitled.

56. McGowan and McGowan Hood's conduct caused a breach of the valid contract by Presley and/or intentionally frustrated Presley's contractual obligation to reimburse the Plan for its medical expenses from funds recovered in the third party action.

57. Plaintiffs have been damaged by the breach because they paid out $199,911.94 in medical costs for which they are entitled to reimbursement, and McGowan and McGowan Hood's misconduct has prevented the Plan from being reimbursed.

58. Accordingly, and by reason of the foregoing, Plaintiffs are entitled to an award of monetary damages in an amount to be determined at trial but, in all events, not less than the sum of the Subrogation Funds ($199,911.94), plus accrued interest thereon, and all consequential damages (including attorneys fees and expenses) as applicable.

COUNT IV

(Defendants Have Converted the Subrogation Funds in which Defendants Acknowledged the Plan has an Interest)

59. Plaintiffs repeat and reallege each and every allegation set forth in paragraphs 1 through 58 as if fully set forth herein.

60. McGowan and McGowan Hood knew of the Plan's entitlement to the full $199,911.94 Subrogation Funds prior to disbursing $49,911.94 of the Subrogation Funds to Presley.

61. By disbursing the $49,911.94, McGowan and McGowan Hood have converted this portion of the Subrogation Funds which are the Plan's funds.

62. By refusing to release from trust the remaining $150,000 of the Subrogation Funds, McGowan and McGowan Hood have converted this portion of the Subrogation Funds.

63. Lexington has suffered, and continues to suffer, significant damages, including, but not limited to, loss of use of the funds it should have received as Subrogation Funds and all accrued interest thereon, and the opportunity cost associated therewith, and the accumulation of legal costs and fees (including attorneys' fees and expenses) incurred as a result Defendants' conversion.

64. Accordingly, the Plan is entitled to an award of monetary damages in an amount to be determined at trial for the loss of the Subrogation Funds, lost opportunity, the accrued interest, and legal fees and expenses, as a result of Defendants' conversion.

COUNT V

(ERISA and State Law Promissory Estoppel)

65. Plaintiffs repeat and reallege each and every allegation set forth in paragraphs 1 through 64 as if fully set forth herein.

66. McGowan Hood made an unambiguous promise to the Plan and/or the Plan's claims administrator or the Plan's counsel to hold the full amount of the Subrogation Funds in trust if the Plan did not agree to reducing its lien from $199,911.94 to $150,000.

67. The Plan relied on this promise.

68. The Plan's reliance on this promise was expected and foreseeable by McGowan Hood.

69. The Plan relied on this promise to its detriment because McGowan Hood has not held the full amount of the Subrogation Funds in trust. Instead, McGowan Hood has disbursed all but $150,000 of the Subrogation Funds.

70. Therefore, the Plan's ability to recover and obtain reimbursement for the full Subrogation Funds is now jeopardized compared to what its ability to recover would be if the full amount of the Subrogation Funds were held in trust, as promised by McGowan Hood.

COUNT VI

(Constructive Trust under 29 U.S.C. § 1132(a)(3))

71. Plaintiffs repeat and reallege each and every allegation set forth in paragraphs 1 through 70 as if fully set forth herein.

72. Lexington, as fiduciary on behalf of the Plan, seeks equitable relief under ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3), to impose an equitable lien and constructive trust on, and to recoup from Defendants, the settlement amount paid by the Plan of $199,911.94, which was the amount that the Plan provided in benefits to Presley.

73. The Plan document authorizes imposition of an equitable lien on overpayments, imposition of a constructive trust on overpayments, and recoupment of the overpayments.

74. This Court should, upon imposing an equitable lien and constructive trust in favor of Lexington, enter judgment in favor of Lexington, for the amount of $199,911.94.

PRAYER FOR RELIEF

WHEREFORE, Plaintiffs respectfully request (i) an order, pursuant to section 542 of the Bankruptcy Code, requiring Defendants to immediately turnover the Subrogation Funds and all accrued interest thereon, at the state judgment rate, to the Plan; (ii) a judgment declaring that Defendants have violated Plaintiffs' right to reimbursement and an injunction ordering Defendants to immediately pay to Plaintiffs, in full, the Subrogation Funds and all accrued interest thereon pursuant to 29 U.S.C. § 1132; (iii) a judgment that Defendants McGowan and McGowan Hood have tortiously interfered with the contractual relations between the Plan and Presley and must pay Plaintiffs monetary damages, in an amount to be determined at trial but, in all events, no less than the sum of $199,911.94, plus accrued interest, and applicable attorneys' fees; (iv) a judgment that Defendants converted the Subrogation Funds and must pay Plaintiffs monetary damages, in an amount to be determined at trial but, in all events, no less than the sum of $199,911.94 plus accrued interest and applicable attorneys' fees; (v) a judgment that the Plan has established a promissory estoppel claim against Defendant McGowan Hood and is entitled to monetary damages, in an amount to be determined at trial but, in all events, no less than the sum of $199,911.94 plus accrued interest and applicable attorneys' fees; (f) a judgment imposing an equitable lien and constructive trust in favor of Lexington for the amount

of $199,911.94; and (g) such other and further relief, including interest, costs, and attorneys' fees, as the Court deems just and proper.

Dated: May 17, 2011
New York, New York

/s/ Adam P. Strochak
Richard P. Krasnow
Adam P. Strochak

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Attorneys for Reorganized Debtors and
Lexington Precision Corporation Group
Medical Care Plan

Exhibit A

Summary Plan Description for the Plan

Summary Plan Description

Lexington Precision Corporation Group Medical Care Plan

Effective Date of Amended Plan: January 1, 2005

Claims Administrator

United Medical Resources, Inc.
P.O. Box 145804
Cincinnati, Ohio 45250-5804

513-619-3000
1-800-950-4867 Toll-Free

8:30 a.m. – 5:00 p.m. EST/EDT

http://www.umr.com

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INTRODUCTION

Your Health Care Plan

Lexington Precision Corporation is pleased to present its benefit plan, a comprehensive plan to help you meet the needs of your *family* and to protect you from the high cost of health care services. The amended *Plan* became effective January 1, 2005, and provides medical coverage for you and your eligible dependents. The *Plan*, as described in this Summary Plan Description (SPD), represents Lexington Precision Corporation's continuing interest in helping you meet your financial responsibilities for your *family's* health care.

This SPD outlines eligibility requirements, services covered, and *Plan* limits, as well as how to file a claim and how to find an answer when you have a question. We recommend that you read all of this SPD because many of the topics are interrelated; reading just one or two parts may result in a misunderstanding. As you review the material, please note that the words and phrases that you find in *italics* are further explained in the PLAN DEFINITIONS section. If you have any questions that do not appear to be covered in this SPD, please contact the *claims administrator,* United Medical Resources (*UMR*). *UMR* keeps the records of individual *Plan participants* and performs claims administration services for the *Plan. UMR's* address is listed at the end of this SPD.

The *Plan* requires *employee* contributions that will be determined annually by the *employer.*

Special Plan Features

Special features of this *Plan* are designed to help contain the ever-increasing costs of health care. These cost-effective features include:

Preferred Provider Organization (PPO)

A preferred *provider* organization, commonly known as a PPO, is a network of *hospitals* or *physicians* (or both) who have agreed to offer health care services at a reduced rate. In exchange, they receive marketing support from the PPO, generally resulting in a greater volume of patients.

The PPO plan option allows you to exercise control over the cost of your health care by choosing an in-network *provider*. For example:

- Benefits for *hospital* services, *physician* services, and other non-hospital services rendered by a member of the PPO are provided at a negotiated, discounted rate. These discounts translate into savings for you because your coinsurance is based on a lower dollar amount.
- Benefits for *hospital* services, *physician* services, and other non-hospital services rendered by a *provider* that is NOT a member of the PPO network are based on the *usual, customary*, *and reasonable charges*. You may receive services from an out-of-network *provider;* however, your claims will be reimbursed at a lower rate. You will be held responsible for your coinsurance **and** for any amounts over the *usual, customary, and reasonable charges*. Refer to the MEDICAL BENEFITS section of this Summary Plan Description for specific details.

When you receive services from a PPO service *provider,* the *provider* will submit the claim to *UMR* on your behalf. Additional information about this option, as well as a list of participating *providers,* will be provided free of charge to covered *employees* and updated as needed.

Additional Features of this Plan

Additional services provided by this *Plan* include: Pre-Certification of Inpatient Services, Pre-Certification of Outpatient Services, and Pre-Determination of Benefits.

The above-referenced *Plan* features are designed to ensure that you receive the most appropriate and cost-effective treatment. These programs are described in detail in the **Health Management Services and Special Provisions** section of this Summary Plan Description.

Section 125

This *Plan* is part of Lexington Precision Corporation's Section 125 flexible benefits plan that allows you to elect health care coverage and pay your contributions on a pre-tax basis. This tax-saving advantage allows you to have a portion of your compensation deducted from your paycheck before your taxes are calculated. In this way, you pay for your health care coverage with pre-tax dollars, you pay less in taxes, and you take home more pay.

Rights and Limits

This SPD provides a general description of the *Plan* and your benefits. It is important to remember that:

- The description of benefits in this Summary Plan Description replaces and supersedes any other Summary Plan Description previously issued by Lexington Precision Corporation.
- All benefits are subject to the terms, conditions, and limitations of the Lexington Precision Corporation Group Medical Care Plan as set forth in the *Plan Document.*
- No *Plan* provision is intended to provide *employees*, former *employees*, or *covered dependents* with a vested right to any benefits under the *Plan* and/or any rights for continued employment.
- Your rights, if any, to benefits of the *Plan* depend upon whether you satisfy the eligibility requirements of the *Plan* and whether your submitted claims are *covered charges* under the *Plan*.
- Your rights as a participant in this *Plan* are outlined in the **ERISA Information** section.

Medical Necessity of Services

This *Plan* covers only those procedures, services, and supplies that are *medically necessary* unless otherwise specified. For a service to be *medically necessary* and covered by the *Plan*, it must be considered necessary for the diagnosis or treatment of an *illness* or *injury* and the care must be given at the appropriate level.

Presumption of Exclusion

This *Plan* provides for those expenses expressly described within, and any omission shall be presumed to be an exclusion.

ELIGIBILITY AND ENROLLMENT

Eligible Employees and Effective Dates

An eligible *employee* is:

A. An individual actively employed by any *employer* or division of any *employer* that has adopted this *Plan*, and who regularly works 30 or more hours per week; or

B. An individual who would be an *employee* as defined in paragraph A of this section but for the individual's taking leave pursuant to the Family and Medical Leave Act; or

C. An individual not described in A or B above but who is within a class of *employees* that any *employer* who has adopted this *Plan* identifies, with the consent of an authorized executive officer of Lexington Precision Corporation, as being eligible to participate in the *Plan*, including duly elected non-*employee* officers of the *employer* and their dependents and certain *employees* designated by the *employer* who resign voluntarily or who are terminated by the *employer* and who voluntarily enter into a severance agreement with the *employer* that is satisfactory to the *employer*. However, participation in the *Plan* for certain *employees* designated by the *employer* who resign voluntarily or who are terminated by the *employer* subsequent to such voluntary resignation or termination shall be at the sole discretion of the *employer*. Furthermore, the length of time that such *employees* who resign voluntarily or are terminated by the *employer* are allowed to participate in the *Plan* shall be at the sole discretion of the *employer*, but in no case shall such participation in the *Plan* exceed one year in length. For an *employee* who enrolls when first eligible, coverage begins on the 91st day of continuous employment, provided the *employee* is *actively at work* and has submitted a completed enrollment form to the Human Resources Department prior to his or her 91st day of continuous employment. For a *late enrollee,* coverage begins on the first day of the month following the open enrollment period (December 1 through December 31 of each *Plan Year*), provided the *employee* is *actively at work* and has submitted a completed enrollment form to the Human Resources Department during the open enrollment period.

D. Generally not a leased or contract *employee.* Leased or contract *employees* are not eligible for this *Plan* unless otherwise specified by an authorized executive officer as set forth in paragraph C.

An *employee* who is absent due to a health factor is considered to be *actively at work* for eligibility purposes of the *Plan.* However, you must have actually reported for your first day of employment in order to be eligible for any benefits, even if all other eligibility requirements have been met.

Eligible Family Members and Effective Dates

Eligible *family* members may participate if you, the *employee,* elect *family* coverage as provided by this *Plan.*

Eligible *family* members are an *employee's* legally married *spouse* who is a permanent resident of the United States and each unmarried *dependent child* who is a permanent resident of the United States through the end of the day preceding each child's 19th birthday.

- If a *dependent child* is unmarried and is mentally or physically incapable of earning his or her own living due to permanent, chronic, and *total disability,* he or she may obtain continued coverage if, within 31 days after the date coverage would otherwise be canceled, you submit proof of your child's incapacity to *UMR*. See **ELIGIBILITY FOR DISABLED CHILDREN**.
- If a *dependent child* is an unmarried *full-time student*, he or she is eligible for *family* member benefits up to age 24. See **ELIGIBILITY OF FULL-TIME STUDENTS**.

Benefits for a *covered dependent* begin on the same date as the *employee* if the *covered dependent* is enrolled at the same time as the *employee.* See the **PLAN ENROLLMENT** section for further information.

If both parents are *employees* and are enrolled separately in this *Plan*, then each unmarried, eligible, *dependent child* may be the *covered dependent* of only one parent.

An *employee* may enroll in the *Plan* either as an *employee* or as a *covered dependent* of his or her *spouse* who is enrolled in the *Plan* with *family* coverage, but not both.

Eligibility for Disabled Children

In order for a *disabled dependent child* to be eligible for coverage under the *Plan* after his or her 19th birthday, he or she:

- must be incapable of self-support because of mental retardation or a permanent, chronic, and *total disability* that commenced prior to age 19 (or prior to age 24 if he or she is a *full-time student*),
- must be principally supported by the *employee*, and
- must be continuously *totally disabled* and covered thereafter.

If you believe a *covered dependent* of yours meets the *total disability* criteria above, obtain a statement from the attending *physician* indicating the complete diagnosis and prognosis of the *covered dependent*. This information must be submitted to the Human Resources Department within 31 days of the date the *covered dependent* attains age 19 (or prior to age 24 if he or she continues as a *full-time student*). This information will be reviewed by the *Plan* to determine eligibility for continued benefits under the *Plan*. You may be required to submit additional information in connection with the eligibility determination.

You will be notified if the *covered dependent* is eligible for benefits under the *Plan* as a *disabled dependent child*. If such eligibility is approved, you may be further required, usually not more frequently than once a year, to furnish satisfactory evidence to substantiate the continued eligibility of such a *covered dependent* for benefits under the *Plan*.

Eligibility of Full-Time Students

In order for a *dependent child* to be eligible for benefits under the *Plan* as a *full-time student* after attaining age 19 up to his or her 24th birthday, he or she:

- must not be employed on a regular, full-time basis;
- must not be covered under any employee group insurance or prepayment plan other than either parent's group coverage; and
- must be enrolled full-time in a recognized course of study or training at an accredited institution such as a:
  - high school or vocational school supported or operated by the local, state, or federal government;
  - state university, college, or community college; or
  - licensed private school, college, or university.

A *covered dependent* who is a *full-time student* must submit a copy of his or her current school schedule to *UMR* once per school term, **before the new term begins.** Failure to do so could result in a lapse in coverage.

Coverage of a dependent who qualifies as a *full-time student* continues during a regularly scheduled vacation period or between-term period as established by the institution. Work limited to such periods is not considered employment on a regular, full-time basis.

Coverage of a dependent who no longer qualifies as a *full-time student* ceases immediately (or at the end of the summer semester, if applicable).

Qualified Medical Child Support Orders

This *Plan* complies with all *Qualified Medical Child Support Orders (QMCSOs)*.

The *QMCSO* will require that the *Plan* cover the children even if the *employee* does not want to enroll the children in the *Plan* or wishes to drop the children's medical coverage.

Plan participants and beneficiaries may obtain, without charge, a description of the procedures governing QMCSO determinations from the *Plan Administrator*.

Plan Enrollment

The Human Resources Department provides you with information about your coverage and an enrollment form prior to the date you become eligible for coverage. Carefully review the material, complete the enrollment form, and return it to the Human Resources Department as soon as possible.

New Employee Enrollment

You become eligible to participate in the *Plan* on your 91st day of continuous employment, provided that you submit a completed enrollment form to the Human Resources Department prior to your 91st day of continuous employment. If you are absent from work on the effective date of coverage, you and, if applicable, your dependents will not become participants in the *Plan* until such time as you return to work and complete one full day of employment.

Open Enrollment Period

If you fail to enroll in the *Plan* when first eligible to enroll, then you (*late enrollee*), in the absence of special circumstances set forth below, may only apply for enrollment in the *Plan* for yourself and your eligible dependents during subsequent open enrollment periods (December 1 through December 31 of each *Plan Year*) by completing an enrollment form and submitting it to your Human Resources Department.

If you or any of your *covered dependents* become covered by *Medicare* or other group coverage, notify the Human Resources Department.

Special Enrollment Periods

This *Plan* provides two special enrollment periods that allow you to enroll in the *Plan* before the next open enrollment period, even if you declined enrollment during your initial enrollment period.

If you or an eligible dependent wants to make application for coverage more than 31 days from the date of eligibility, you must wait until the next open enrollment period or until you incur a change in status. (See **Changes in Plan Elections on a Pre-Tax Basis**, **Loss of Other Coverage**, and **New Dependent**.)

Loss of Other Coverage

If you declined enrollment for yourself or your dependents (including your *spouse*) because of other health coverage, you may in the future be able to enroll yourself or your dependents in this *Plan* during a special enrollment period. You must request enrollment no later than 31 days after the exhaustion of your other health coverage. For example, if you lose your other health coverage on September 15, you would need to notify the *Plan Administrator* by close of business on October 16 that you have lost other coverage.

This special enrollment period is available only to the following individuals:

- **An *employee*** who is eligible for coverage under the terms of the *Plan*, is not enrolled, and, when enrollment was previously offered to the *employee* under the *Plan*, declined because he or she was covered under another group health plan or had other health insurance coverage.
- **A dependent** of an *employee* (i.e., an eligible *employee* actually enrolled in the *Plan*) who is eligible for coverage under the terms of the *Plan*, is not enrolled, and, when enrollment was previously offered to the dependent under the *Plan*, declined because he or she was covered under another group health plan or had other health insurance coverage.
- **An *employee* and dependent** of an eligible *employee*, in the case where they are eligible for coverage under the terms of the *Plan*, are not enrolled, and, when enrollment was previously offered to the *employee* or dependent under the *Plan*, declined because the *employee* or dependent was covered under another group health plan or had other health insurance coverage.

To qualify for this special enrollment period, the following conditions apply:

- You must have submitted a written statement at your initial opportunity to enroll in the *Plan*, stating that other health coverage was the reason for declining enrollment in this *Plan*.
- When you declined enrollment for yourself or your dependent, you or your dependent had COBRA continuation coverage under another plan and such COBRA has since been exhausted.

  NOTE: Your COBRA is considered exhausted when your COBRA continuation coverage ceases for any reason other than either your failure to pay premiums on a timely basis, or improper or illegal acts (such as making a fraudulent claim or an intentional misrepresentation to the plan). You are also considered to have exhausted COBRA continuation coverage if such coverage ceases (a) due to the failure of the employer or other responsible entity to remit premiums on a timely basis, or (b) when you no longer reside, live, or work in a service area of an HMO or similar program (whether or not within your choice) and there is no other COBRA continuation coverage available to you.
- If the other health coverage, when enrollment was declined, was not COBRA continuation coverage or COBRA coverage was not elected, the coverage was terminated either due to loss of eligibility for the coverage (including due to legal separation, divorce, death, termination of employment, or reduction in the number of hours) or because employer contributions for the coverage were terminated.

  You will not be considered to have a loss of eligibility (see above) if you lose the coverage as a result of your failure to pay premiums on a timely basis or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan).
- To have special enrollment rights for loss of coverage, you must completely exhaust your COBRA or other health coverage, i.e., you must continue the coverage for as long as it is available to you. Therefore, if you prematurely stop your COBRA or other coverage (for example, by ceasing to pay premiums), you will not be entitled to a special enrollment period for loss of coverage.
- You must request special enrollment in writing, and the request must be received by the *Plan* no later than 31 days after the date your COBRA was exhausted. If your coverage was other than COBRA, you must request the special enrollment no later than 31 days after the termination of coverage or employer contributions.

If you meet the preceding conditions and have submitted a written request for special enrollment within 31 days after the loss of coverage, the enrollment of you or your dependent will be effective on the first day after the loss of such other coverage.

New Dependent

If you obtain a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents during a special enrollment period. You must request enrollment no later than 31 days after you obtain the new dependent. For example, if you are married on September 15, you would need to notify the *Plan Administrator* by close of business on October 16 that you have obtained a new dependent.

This special enrollment period is available only to the following individuals:

- **An *employee*** who is eligible, who is not enrolled in the *Plan*, who would be a participant except for a prior election not to enroll in the *Plan* during a previous enrollment period, and who obtains a dependent through marriage, birth, adoption, or placement for adoption.
- **The new *spouse* of an *employee*** (i.e., an eligible *employee* actually enrolled under the *Plan*).
- **The current *spouse* of an *employee*** in the case where a child becomes a dependent of the *employee* through birth, adoption, or placement for adoption.
- **An *employee* who is eligible, and the *spouse* of the *employee*,** if the *employee* is not enrolled in the *Plan,* would be a participant except for a prior election by the *employee* not to enroll in the *Plan* during a previous enrollment period, and either (a) the *employee* and the *spouse* have just become married, or (b) the *employee* and the *spouse* have been married and a child becomes a dependent of the *employee* through birth, adoption, or placement for adoption.
- **A dependent of an *employee*** (i.e., an eligible *employee* actually enrolled under the *Plan*) who becomes a dependent of the *employee* through birth, adoption, or placement for adoption.
- **An *employee* who is eligible and a dependent of such *employee*,** if the *employee* is not enrolled in the *Plan,* would be a participant but for a prior election by the *employee* not to enroll in the *Plan* during a previous enrollment period, and the dependent becomes a dependent of the *employee* through birth, adoption, or placement for adoption.

To qualify for this special enrollment period, you must request special enrollment in writing, and the request must be received by the *Plan* no later than 31 days after the date of the marriage, birth, adoption, or placement for adoption.

The enrollment of you or your dependent will be effective on the following dates:

- For a marriage, the date of the marriage. (Retroactive *employee* contributions may not be taken on a pre-tax basis.)
- For a birth, the date of birth.
- For an adoption or placement for adoption, the date of the adoption or placement for adoption.

Changes in Plan Elections on a Pre-Tax Basis

Generally, you may make a change in the *Plan* options you elected at your initial enrollment **only** at the next open enrollment period. The open enrollment period takes place prior to the beginning of each *Plan Year*.

However, you may change your level of coverage before the next open enrollment period if you experience a change in status. The change in coverage must be on account of and consistent with a change in status event that affects coverage eligibility of the *employee*, a *spouse*, or a dependent under an employer's plan. A change in status includes:

- marriage.

- divorce, legal separation, or annulment.
- birth, adoption, or placement for adoption of a child.
- death of a *spouse* or *dependent child*.
- termination or commencement of employment by you, your *spouse*, or your *dependent child*.
- reduction or increase in hours of employment by you, your *spouse*, or your *dependent child* (including a switch from part-time to full-time employment status or vice versa, a strike, or a lockout).
- place of residence change by you, your *spouse*, or your *dependent child* that results in a change in eligibility.
- your *dependent child* satisfies or ceases to satisfy the requirements for coverage due to attainment of age, student status, or any similar circumstance as provided in the *Plan*.
- any other change in status that the *claims administrator* determines will permit a change or revocation of an election during a *Plan Year* under regulations and rulings by the Internal Revenue Service.

If you experience such a change in status and wish to change your level of coverage, you must submit written notification to the Human Resources Department no later than 31 days after your change in status. The *claims administrator* reserves the right to require the applicant to submit proof of any change in status at the applicant's expense. The change in coverage becomes effective the date of the event. Retroactive *employee* contributions will be taken on a pre-tax basis only as permitted under Section 125 of the Internal Revenue Code.

If you declined coverage when first hired, you may enroll in this *Plan* during the open enrollment period (December 1 through December 31).

CONTINUATION OF COVERAGE

Continuation of Coverage Under FMLA

This *Plan* allows for the continuation of coverage for a leave of absence, subject to the Family and Medical Leave Act of 1993, for up to 12 weeks in a 12-month period.

- If you are no longer *actively at work* due to an approved personal leave of absence and/or an approved medical leave of absence that commenced on or after August 5, 1993;
- if you have worked at least 1250 hours in the past 12-month period; and
- if you and your *employer* meet the criteria of the Family and Medical Leave Act of 1993 (PL 103-3),

then you (and your *covered dependents*) are eligible for continuation of coverage under the *Plan* for up to 12 weeks, provided you continue to make the same monthly contribution you were making while *actively at work.* This initial 12-week period may include accrued sick time and/or vacation time and must occur concurrently with the time period allowed for a continuation of coverage for Short Term Disability or a continuation of coverage for personal leave of absence.

At the end of the initial 12-week period or when your employment is terminated, whichever comes first, you (and your *covered dependents*) may be eligible for continuation of coverage as provided by COBRA guidelines. You are responsible for the full COBRA rate of contribution for the continuation coverage under COBRA period.

At the end of the initial 12-week period or when you return to *actively at work* status, whichever comes first, you (and your *covered dependents*) may either continue to maintain coverage or resume coverage under this *Plan* as an eligible active *employee.* This continuation of coverage may resume without having to complete a new waiting period and without being subject to a new *pre-existing conditions* limitations provision.

Continuation of Coverage for Leave of Absence

If you are a full-time *employee* and obtain an approved leave of absence for medical reasons, you (and your *covered dependents*) may be eligible for continuation of medical coverage under this *Plan*, provided you continue to pay your portion of the coverage costs and you are an *employee* of Lexington Precision Corporation. Refer to your Human Resources Department to determine the length of time that continuation coverage may be granted to you for medical leave of absence. Continuation of coverage granted under this provision may be extended per guidelines established by the Americans with Disabilities Act (usually not to exceed 2 weeks).

At the end of coverage for leave, you may be eligible for continuation of coverage as described in the **CONTINUATION OF COVERAGE UNDER COBRA** section.

Continuation of Coverage for Layoff

If you are a full-time *employee* and are laid off, you (and your *covered dependents*) are eligible for continuation of medical coverage under this *Plan* for a period of up to 7 days from the first day of the layoff or through the end of the month in which you are laid off, whichever is longer.

At the end of coverage for layoff, you may be eligible for continuation of coverage as described in the **CONTINUATION OF COVERAGE UNDER COBRA** section.

Continuation of Coverage for Disability

If you are a full-time *employee* and become *disabled* and obtain an approved medical leave of absence, you (and your *covered dependents*) may be eligible for continuation of medical coverage under this *Plan*, provided you continue to pay your portion of the coverage costs and you are an *employee* of Lexington Precision Corporation. Refer to your Human Resources Department to determine the length of time that continuation coverage may be granted to you for medical leave of absence. Continuation of coverage granted under this provision may be extended per guidelines established by the Americans with Disabilities Act (usually not to exceed 2 weeks).

If, at the end of coverage for *disability,* you continue to be *disabled*, you may be eligible for continuation of coverage as described in the **Continuation of Coverage Under COBRA** section.

Continuation of Coverage Upon Retirement

If you are a full-time *employee* and retire from Lexington Precision Corporation, you (and your *covered dependents*) may be eligible for continuation of coverage as described in the **Continuation of Coverage Under COBRA** section.

Continuation of Coverage for Military Leave

If you are called to active military duty, you and your *covered dependents* may be eligible for coverage under TRICARE, the *military service's* health plan. You and your *covered dependents* may also elect to continue benefits under this *Plan* if you were covered by the *Plan* at the time you were called to military duty.

This *Plan* allows for the continuation of coverage for a military leave of absence, covered by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). Coverage may be continued until the earlier of:

- twenty-four months after your absence from work begins, or
- the day after the date on which you fail to timely apply for or return to employment as required under USERRA.

If you elect to continue coverage and your *military service* is less than 31 days, you are only required to pay your normal share of the premium for such coverage. If the length of your *military service* extends past 31 days, you must pay 102% of the cost of the *Plan* for similarly situated *Plan participants* who are not serving in a *military service*.

If you choose not to continue coverage under this *Plan* during your *military service*, you and your *covered dependents* are eligible for reinstatement of coverage on the date you return with reemployment rights guaranteed under USERRA. However, the reinstatement of coverage will be subject to any waiting periods or any limitations for *pre-existing conditions* that would have otherwise applied had you not left for *military service*. In addition, as permitted by USERRA, your coverage will not include any *illness* or *injury* determined by the Secretary of Veteran Affairs to have been incurred in, or aggravated during, performance of *military service*. Any other such *illness* or *injury* will be covered by the *Plan*, subject to all otherwise applicable conditions and limitations of the *Plan*.

Note: After your USERRA continuation coverage expires, you will not thereafter receive 18 months of COBRA continuation coverage. However, if your USERRA coverage expires prior to 18 months (e.g., because you do not return to employment), you may be eligible for COBRA continuation coverage for the remainder of the original 18-month COBRA coverage period.

COBRA

Continuation of Coverage Under COBRA

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA). COBRA continuation coverage may become available to you when you otherwise would lose your group health coverage. It may also become available to other members of your *family* who are covered under the *Plan* when they otherwise would lose their group health insurance.

Qualifying Events for Covered Employees and Family Members

COBRA provides a continuation of *Plan* coverage when coverage otherwise would end because of a qualifying event. Specific qualifying events are listed below. When you experience a qualifying event, the *Plan* must offer COBRA continuation coverage to each person who is a *qualified beneficiary*. You, your *spouse*, and your *dependent children* may become *qualified beneficiaries* if coverage under the *Plan* is lost because of a qualifying event.

If you are a covered *employee* (meaning you are an *employee* and are covered under the *Plan*), you will become a *qualified beneficiary* if you lose your coverage under the *Plan* due to any of the following qualifying events:

- Your hours of employment are reduced.
- Your employment ends for any reason other than your gross misconduct.

Your *spouse* will become a *qualified beneficiary* if your *spouse* loses coverage under the *Plan* due to any of the following qualifying events:

- You die.
- Your hours of employment are reduced.
- Your employment ends for any reason other than your gross misconduct.
- You become entitled to *Medicare* benefits. (*Medicare* entitlement is rarely considered a qualifying event, since it will typically not cause a loss of coverage under the terms of the *Plan*.)
- You become divorced or legally separated from your *spouse*.

Your *dependent children* will become *qualified beneficiaries* if they lose coverage under the *Plan* due to any of the following qualifying events:

- You die.
- Your hours of employment are reduced.
- Your employment ends for any reason other than your gross misconduct.
- You become entitled to *Medicare* benefits. (*Medicare* entitlement is rarely considered a qualifying event, since it will typically not cause a loss of coverage under the terms of the *Plan*.)
- You and your *spouse* become divorced or legally separated.
- The child ceases to be eligible for coverage under the *Plan* as a *dependent child*.

COBRA Continuation Coverage Notification and Election

COBRA continuation coverage procedures include specific notice requirements for the *employer*, Lexington Precision Corporation, for the *qualified beneficiary*, and for the *Plan Administrator*. Complete instructions on how to elect COBRA continuation coverage will be provided by the *Plan Administrator*

within 14 days of receiving the notice of your qualifying event. You will then have 60 days in which to elect COBRA continuation coverage. The 60-day period is measured from the later of the date coverage terminates or the date of the notice containing the instructions. If you do not elect COBRA continuation coverage within that 60-day period, then your right to elect COBRA continuation coverage ceases. Refer to the **Providing Notification and Election Notices** section of this SPD for the specific name and address of where notices are to be sent.

Each *qualified beneficiary* will have an independent right to elect COBRA continuation coverage. Covered *employees* may elect COBRA continuation coverage on behalf of their *spouses* and *dependent children*.

In the event that the *Plan Administrator* determines that the individual is not entitled to COBRA continuation coverage, the *Plan Administrator* will provide to the individual an explanation as to why he or she is not entitled to COBRA continuation coverage.

Notice from a Qualified Beneficiary

The Plan will offer COBRA continuation coverage to *qualified beneficiaries* only after the *Plan Administrator* has been notified that a qualifying event has occurred.

The *qualified beneficiary* must notify the *Plan Administrator* when any of these qualifying events occurs:

- Divorce.
- Legal separation.
- Child's loss of dependent status.
- A second qualifying event after an individual has become entitled to COBRA continuation coverage with a maximum duration of 18 (or 29) months.

The *qualified beneficiary* must notify the *Plan Administrator* in writing by the date that is 60 days after the latest of:

- The date of the qualifying event.
- The date coverage would be lost under the *Plan*.
- The date on which the *qualified beneficiary* is informed through the SPD or general notice of his or her responsibility to provide the notice and the *Plan's* procedures for providing the notice to the *Plan Administrator*.

The following actions must then be taken:

- The *Plan Administrator* must notify the *qualified beneficiary* within 14 days after such preceding notice of his or her election rights for COBRA continuation coverage.
- The *qualified beneficiary* must then notify the *Plan* in writing within 60 days after such preceding notice if he or she wants COBRA continuation coverage. Waiver of coverage is automatic if no election is received within 60 days.

Each *qualified beneficiary* making notice to the *Plan* may obtain a qualifying event notice, free of charge, from the *Plan Administrator*, or provide his or her own notice that contains all of the required information as outlined under the **Required Contents of the Notice** section of this SPD.

If you have already begun receiving COBRA continuation coverage and one of these events occurs:

- Death of covered *employee*.
- Divorce.

- Legal separation.
- Child's loss of dependent status.

The following action must be taken:

- The *qualified beneficiary* must notify the *Plan* in writing within 60 days of whether or not he or she wants COBRA continuation coverage.

In these situations, COBRA continuation coverage may be extended up to 36 months from the date of the original qualifying event.

If you have already begun receiving COBRA continuation coverage and one of these events occurs:

- Former covered *employee* gives birth.
- Former covered *employee* adopts a child.

The following action must be taken:

- The *qualified beneficiary* must notify the *Plan Administrator* of the birth or adoption within 30 days of the event.

In these situations, the former covered *employee* is entitled to add the newborn or newly adopted child to the *Plan* as a *qualified beneficiary*.

Notice from an Employer

The *Plan* will offer COBRA continuation coverage to *qualified beneficiaries* only after the *Plan Administrator* has been notified that a qualifying event has occurred.

The *employer* must notify the *Plan Administrator* when any of these qualifying events occurs:

- Death of covered *employee*.
- Termination of employment.
- Reduction in hours.
- Covered *employee's* entitlement to *Medicare*. (*Medicare* entitlement is rarely considered a qualifying event, since it will typically not cause a loss of coverage under the terms of the *Plan*.)

The following actions must then be taken:

- The *Plan Administrator* must notify the *qualified beneficiary* within 14 days of his or her election rights for COBRA continuation coverage. In certain cases, the preceding notice requirement may be extended to 44 days.
- The *qualified beneficiary* must respond in writing within 60 days, notifying the *Plan* if he or she wants COBRA continuation coverage. Waiver of coverage is automatic if no election is received within 60 days.

COBRA Continuation Coverage for a Disabled Qualified Beneficiary

The following provisions apply to a *qualified beneficiary* who is determined, by the Social Security Administration, to be *disabled* and eligible for COBRA continuation coverage as a result of the covered *employee's* termination of employment or reduction in hours:

The *disabled qualified beneficiary* may elect to extend COBRA continuation coverage from 18 months to 29 months of coverage. This extension to 29 months of coverage applies to all *qualified beneficiaries* who have lost coverage under the *Plan* due to the covered *employee's* termination of employment or reduction in hours, and who have elected COBRA continuation coverage. The *qualified beneficiary's disability* must occur or be determined to be in existence within the first 60 days of COBRA continuation coverage.

The *disability* must be recognized by the Social Security Administration. The *qualified beneficiary* must submit proof of this *disability* in writing to the *Plan Administrator* prior to the end of his or her 18th month of COBRA continuation coverage AND by the date that is 60 days after the latest of:

- The date of the *disability* determination by the Social Security Administration.
- The date on which the qualifying event occurs.
- The date on which the *qualified beneficiary* loses or would lose coverage under the *Plan*.
- The date on which the *qualified beneficiary* is informed, through the SPD or the general notice, of the responsibility to provide the notice and the *Plan's* procedures for providing the notice to the *Plan Administrator*.

The *Plan Administrator* may charge the *disabled qualified beneficiary* with COBRA continuation coverage up to 150% of the applicable contributions for the COBRA continuation coverage for the 19th through 29th months of COBRA continuation coverage.

A *qualified beneficiary* who experiences a change in *disability* status in which the Social Security Administration determines the *qualified beneficiary* is no longer *disabled* must notify the *Plan Administrator* in writing by the date that is 30 days after the later of:

- The date of the final determination by the Social Security Administration that the *qualified beneficiary* is no longer *disabled*.
- The date on which the *qualified beneficiary* is informed, through the *Plan's* SPD or general notice, of the responsibility to provide the notice and the *Plan's* procedures for providing such notice to the *Plan Administrator*.

The *Plan Administrator* may terminate the extended coverage in the month that begins more than 30 days after a determination that the *qualified beneficiary* is no longer *disabled*. The right to maintain COBRA continuation coverage past the initial 18 months terminates at the same time the *qualified beneficiary's disability*, as determined by the Social Security Administration, ends.

Providing Notification and Election Notices

The *qualified beneficiary* is responsible for providing the *Plan Administrator* with the qualifying event notice and election notice, in writing, either by U.S. First Class mail or hand delivery. The notice must be postmarked (if mailed) or received by the *Plan Administrator* (if hand delivered) by the deadline set forth above. If the notice is late, the opportunity to elect or extend COBRA continuation coverage will be lost. If you are electing COBRA continuation coverage, your coverage under the *Plan* will terminate on the last date for which you are eligible under the terms of the *Plan*, or if you are extending COBRA continuation coverage, such coverage will end on the last day of the initial 18-month COBRA continuation coverage period.

All qualifying event and election notices should be directed to your plant Human Resources as follows:

LEXINGTON PRECISION CORPORATION HUMAN RESOURCE DEPARTMENTS	
LEXINGTON CONNECTOR SEALS 1510 Ridge Road Vienna, Ohio 44473 Phone: 330-856-1121 Fax: 330-856-8158	LEXINGTON INSULATORS 1076 Ridgewood Road Jasper, Georgia 30143 Phone: 706-692-2417 Fax: 706-692-8592

LEXINGTON PRECISION CORPORATION HUMAN RESOURCE DEPARTMENTS	
LEXINGTON TECHNOLOGIES 3565 Highland Park Street, NW N. Canton, Ohio 44720 Phone: 330-305-1040 Fax: 330-305-1045	LEXINGTON DIE CASTING 201 Winchester Road Lakewood, New York 14750 Phone: 716-763-8521 Fax: 716-763-3710
LEXINGTON LSR 3565 Highland Park Street, NW N. Canton, Ohio 44720 Phone: 330-305-1040 Fax: 330-305-1045	LEXINGTON MEDICAL 663 Bryant Boulevard Rock Hill, South Carolina 29732 Phone: 803-366-7036 Fax: 803-366-7093
LEXINGTON PRECISION CORPORATION – Corporate Office 30195 Chagrin Boulevard, Suite 208W Cleveland, Ohio 44124 Phone: 216-591-1070 Fax: 216-591-1077	

Any individual who is a *qualified beneficiary* with respect to the qualifying event, or any representative acting on behalf of the *qualified beneficiary*, may provide the notice, and the provision of notice by one individual shall satisfy any responsibility to provide notice on behalf of all related *qualified beneficiaries* with respect to the qualifying event.

Required Contents of the Notice

The notice must contain the following information:

- Name and address of the covered *employee*.
- If you are already receiving COBRA continuation coverage and wish to extend the maximum coverage period, identification of the initial qualifying event and its date of occurrence.
- A description of the qualifying event (for example, divorce, legal separation, or a *dependent child's* loss of dependent status).
- In the case of divorce or legal separation, the name(s) and address(es) of the *spouse* and *dependent child(ren)* covered under the *Plan*, the date of divorce or legal separation, and a copy of the decree of divorce or legal separation.
- In the case of a covered *employee's* entitlement to *Medicare*, the name of the covered *employee*, the date of entitlement, and the name(s) and address(es) of the *spouse* and *dependent child(ren)* covered under the *Plan*.
- In the case of a *dependent child's* cessation of dependent status under the *Plan*, the name and address of the child and the reason the child ceased to be an eligible dependent (for example, attainment of limiting age, loss of student status, or marriage).
- In the case of the death of a covered *employee*, the date of death and the name(s) and address(es) of the *spouse* and *dependent child(ren)* covered under the *Plan*.
- In the case of a *disability* of a *qualified beneficiary*, the name and address of the *disabled qualified beneficiary*, the name(s) and address(es) of other *family* members covered under the *Plan*, the date the *disability* began, the date of the Social Security Administration's determination, and a copy of the determination.

- In the case of a loss of *disability* status, the name and address of the *qualified beneficiary* who is no longer *disabled*, the name(s) and address(es) of other *family* members covered under the *Plan*, the date the *disability* ended, and the date of the Social Security Administration's determination.
- A certification that the information is true and correct, a signature, and the date of the signature.

If you cannot provide a copy of the decree of divorce or legal separation or the Social Security Administration's determination by the deadline for providing the notice, complete and provide the notice, as instructed, by the deadline and submit the copy of the decree of divorce or legal separation or the Social Security Administration's determination within 30 days after the deadline. The notice will be considered timely if you do so. However, no COBRA continuation coverage, or extension of such coverage, will be available until you provide the copy of the decree of divorce or legal separation or the Social Security Administration's determination.

If the notice does not contain all of the required information, the *Plan Administrator* may request additional information. The *Plan Administrator* may reject the notice if the individual fails to provide such information within the time period specified by the *Plan Administrator* in the request, or if it does not contain enough information for the *Plan Administrator* to identify the *Plan*, the covered *employee*, the *qualified beneficiaries*, the qualifying event or *disability*, and the date on which the qualifying event occurred.

COBRA Continuation Coverage and Cost

COBRA continuation coverage is identical to the coverage provided to similarly situated beneficiaries who are covered under the *Plan*. In addition, the *Plan* requires the *qualified beneficiary* to pay the full cost of COBRA continuation coverage and an administrative fee. The total charge may not exceed 102% of the cost of the *Plan* for similarly situated *Plan participants* for whom such a qualifying event has not occurred. The monthly payments are due the first day of each month that COBRA continuation coverage is available and requested. Payments are to be made to Lexington Precision Corporation and mailed to United Medical Resources, Inc.

COBRA Continuation Coverage and Timely Payment

Timely payment is payment that is made to the *Plan* by the date that is 30 days after the first day of that period. Payment that is made to the *Plan* by a later date is also considered timely payment if either under the terms of the *Plan*, covered *employees* or *qualified beneficiaries* are allowed until that later date to pay for their coverage for the period, or under the terms of an arrangement between the *employer* and the entity that provides *Plan* benefits on the *employer's* behalf, the *employer* is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Once you elect COBRA continuation coverage, you must pay for the cost of the initial period of coverage within 45 days. Payments are then due on the first day of each month in order to continue coverage for that month. If a payment is not received within 30 days of the due date, COBRA continuation coverage will be canceled and will not be reinstated. Payment is considered made on the date on which it is sent to the *Plan*.

If timely payment is made to the *Plan* in an amount that is not significantly less than the amount the *Plan* requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the *Plan's* requirement for the amount to be paid, unless the *Plan* notifies the *qualified beneficiary* of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a timely payment is not significant if it is no greater than the lesser of $50 or 10% of the required amount.

COBRA Continuation Coverage Period

COBRA continuation coverage will be available up to the maximum time period shown in the following table. Generally, multiple qualifying events that may be combined under COBRA will not result in continuation coverage for more than 36 months beyond the date of the original qualifying event.

Qualifying Event	Continuation Coverage Period
Termination of employment (other than for gross misconduct) Reduction in hours	up to 18 months, for the covered *employee*, *spouse*, and *dependent child(ren)*
Covered *employee's* death Covered *employee's Medicare* entitlement Divorce Legal separation	up to 36 months, for the *spouse* and *dependent child(ren)*
Child's loss of dependent status	up to 36 months, for the *dependent child*
For *Disabled Plan Participants* Termination of employment (other than for gross misconduct) Reduction in hours	up to 29 months, if determined by the Social Security Administration to be *disabled* at the time of the qualifying event or during the first 60 days of COBRA coverage
Special note: In the event of multiple qualifying events, in some cases continuation coverage may be extended up to 36 months measured from the date of the first qualifying event.	

Special Medicare Rule

If the covered *employee* experiences a termination of employment or reduction in hours (a qualifying event) less than 18 months after the date the covered *employee* became entitled to *Medicare* benefits (the first qualifying event), the maximum coverage period will be 36 months beginning on the date the covered *employee* became entitled to *Medicare*. This 36-month coverage period applies only to covered *spouses* and *dependent children*.

Extended COBRA Continuation Coverage

There are two ways in which the 18-month period of COBRA continuation coverage may be extended.

Disability Extension

If you or any covered *family* member is determined by the Social Security Administration to be *disabled* and you notify the *Plan Administrator* as set forth above, you and your entire *family* may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The *disability* must begin before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. An extra fee will be charged for this extended COBRA continuation coverage.

Second Qualifying Event Extension

If your *family* experiences another qualifying event while receiving 18 months of COBRA continuation coverage, your *spouse* and *dependent child(ren)* may receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months. Proper notice of the second qualifying event must be given to the *Plan* as set forth above. This extension may be available to the *spouse* and any *dependent child(ren)* receiving COBRA continuation coverage if the covered *employee* dies or gets divorced or legally separated, if a covered *employee* becomes entitled to *Medicare* benefits (in rare instances), or if a

dependent child loses eligibility under the *Plan* as a *dependent child*, but only if the event would have caused the *spouse* or *dependent child* to lose coverage under the *Plan* had the first qualifying event not occurred.

Termination of Continuation Coverage Under COBRA

The *Plan* is not required to provide continuation coverage if:

- The *Plan Sponsor* ceases to provide any group health plan to its *employees*.
- The *qualified beneficiary* with COBRA continuation coverage fails to make timely payment of any contributions due.
- The *qualified beneficiary* with COBRA continuation coverage reaches the maximum time period for his or her qualifying event.
- The *qualified beneficiary* with COBRA continuation coverage becomes covered under another group health plan or a covered *employee* becomes entitled to *Medicare* benefits, except as stated under COBRA's special bankruptcy rules.
  - ♦ However, continuation coverage terminates only if the *Plan participant's* amount of *creditable coverage* meets the *pre-existing conditions* limitation of the new plan. You may be able to maintain your continuation coverage, at your expense, for benefits related to a *pre-existing condition*, as excluded by the new group health plan.

If a *disabled qualified beneficiary* recovers from his or her *disability* before the end of the 29-month period, COBRA that has been extended due to the special *disability* extension may be terminated. COBRA coverage may be terminated as of the month that begins more than 30 days after a final determination under the Social Security Administration that the individual is no longer *disabled*. This will terminate not only the *disabled* individual's COBRA continuation coverage, but also that of all non-disabled *qualified beneficiaries* who are entitled to a *disability* extension due to that *disabled* individual's status.

Trade Act of 2002

Two provisions under the Trade Act of 2002 may affect benefits under COBRA. First, certain eligible individuals who lose their jobs due to international trade agreements may receive a 65% tax credit for premiums paid for certain types of health insurance, including COBRA continuation coverage premiums. Second, eligible individuals under the Trade Act who do not elect COBRA continuation coverage within the election period will be allowed an additional 60-day period to elect COBRA continuation coverage. If a *qualified beneficiary* elects COBRA continuation coverage during this second election period, the coverage period will run from the beginning date of the second election period. Consult the *Plan Administrator* if you believe the Trade Act applies to you.

Current Addresses

In order to protect your *family's* rights, keep the *Plan Administrator* informed of any changes to the addresses of *family* members.

Additional Information

Additional information about the *Plan* and COBRA continuation coverage is available from the *Plan Administrator*.

TERMINATION OF COVERAGE

You and your *covered dependents* are no longer eligible for coverage effective the day any one of the following events occurs:

- Your status as an eligible *employee* changes.
- The *Plan* is amended to make your employment classification ineligible.
- Your eligibility to elect COBRA ceases.
- The *Plan* terminates.
- You cease making the required contributions for the *employee* and/or *covered dependent* and the last period for which you made a required contribution has expired.
- You retire.
- You join any *military service* covered by USERRA.
- You or your *covered dependents* defraud or attempt to defraud the *Plan*.

In addition, *covered dependents* are no longer eligible for coverage effective the day any one of the following events occurs:

- Your *covered dependent* other than your *spouse* becomes eligible for benefits as an eligible *employee* of Lexington Precision Corporation.
- Your eligibility to elect COBRA ceases.
- Your *covered dependent* ceases to be dependent upon you for principal support, reaches the age limit, or otherwise no longer meets conditions for eligibility. See **ELIGIBILITY AND ENROLLMENT**.
- You get divorced or legally separated such that your covered *spouse* is no longer eligible for coverage.
- The *Plan* is amended to make the dependent classification ineligible.
- You cease making the required contributions for the *employee* and/or *covered dependent* and the last period for which you made a required contribution has expired.
- Your *covered dependent* joins the military.

Continuation of benefits may be available. See **CONTINUATION OF COVERAGE**.

COORDINATION OF BENEFITS AND SUBROGATION

Coordination of benefits (COB) is a feature of this *Plan* that prevents duplicate payment of *covered charges* if a *Plan participant* is covered under more than one benefits program. In order to ensure that you receive the maximum benefits if you have duplicate coverage, always present both ID cards and take the claim forms (if required) from both benefits programs when you receive a service.

COB determines which benefit plan is the primary payer (which plan pays first), and specifies how much is paid.

Determining the Primary Payer

Several rules are used to determine which benefit plan is the primary payer (or primary carrier) if a person is covered by more than one plan. The rules for primary payer are applied in the following order:

- A benefits plan that does not have a COB feature is always the primary payer.
- In the event of an accident, this *Plan* may not be primary. The other plan may include, but may not be limited to, auto medical insurance coverage, no-fault coverage, casualty, or liability insurance.
- A benefits plan that covers the patient as the *employee* is the primary payer and pays before a plan that covers the patient as a dependent.
- A benefits plan that covers the patient as an active *employee* is the primary payer and pays before a plan that covers the patient as an inactive *employee.*
- If a child is covered under both parents' plans, the plan covering the parent whose **birthday** occurs earlier in the year pays before the plan covering the other parent.
- If the child's parents are divorced or separated, the primary payer is determined in the following order:
  - The plan of the parent who by court order or agency ruling is responsible for the child's health care expenses is the primary payer.
  - If there is no decree, the plan that covers the child as a dependent of the parent who has custody of the child is the primary payer. The plan of the non-custodial parent is secondary.
  - If there is no decree, the plan that covers the child as a dependent of the parent who has custody of the child is the primary payer, and if the custodial parent remarries, the plan of the custodial parent's *spouse* is secondary. The plan of the non-custodial parent is tertiary.
  - If the parents have joint custody of the child, the plan covering the parent whose **birthday** occurs earlier in the year pays before the plan covering the other parent.
  - For purposes of this COB provision, if there is no decree, "custody" shall be determined based upon which parent may claim the child as an IRS dependent.
- If none of the above rules apply, the plan covering the *Plan participant* for the longer period of time pays before the plan covering the *Plan participant* for the shorter period of time.

If this *Plan* is secondary and you receive duplicate payment from the *Plan* and another health benefits plan, the *Plan* will collect that duplicate payment from you.

When this Plan Is Secondary

There are some basics to remember that will help you understand how COB works.

- As secondary payer, this *Plan* pays benefits after your primary plan has paid.

- This *Plan* will never pay more as the secondary plan than it would have paid if it had been the primary plan.

With COB, this *Plan's* benefits are paid up to **this *Plan's* benefit level.** When you submit a claim for a charge that this *Plan* covers at 80% and this *Plan* is determined to be the secondary carrier, this *Plan* pays 80% of the covered benefit less any amount the primary plan or carrier paid.

In the following example, this *Plan* pays up to the **benefit level** of this *Plan* (80% of the allowable charges or $800), less any amount paid by your primary carrier ($300). You are responsible for the unpaid balance of $200.

Example 1 *(assumes deductibles have been met)*	
Amount Billed by Hospital	$1,200
Less PPO Discount	-200
Allowable Plan Charges	$1,000
This Plan's Benefit Level (80% of $1,000)	**$ 800**
Amount Paid by Primary Plan	-300
This Plan Pays the difference between this Plan's benefit and the amount paid by the primary plan.	**$ 500**

In the following example, this *Plan* pays nothing since this *Plan's* benefit level of $800, less the $800 paid by your primary plan, is $0. You are responsible for the unpaid balance of $200.

Example 2 *(assumes deductibles have been met)*	
Amount Billed by Hospital	$1,200
Less PPO Discount	-200
Allowable Plan Charges	$1,000
This Plan's Benefit Level (80% of $1,000)	**$ 800**
Amount Paid by Primary Plan	-800
This Plan Pays	**$ 0**

Coordination of Benefits and Other Plans

The COB provision applies to other benefit plans. These plans include:

- group, blanket, or franchise insurance coverage;
- BlueCross, BlueShield, or other prepayment coverage;
- coverage under a labor-management trusteed plan;
- any union welfare plan;
- an employer organization plan or employee benefit organization plan;
- coverage under any law, including any federal, state, or other governmental plan or law, toward the cost of which any employer shall have made payroll deductions; and

- coverage under any plan solely or largely tax supported or otherwise provided for, by, or through action of any government.

The *Plan* provides benefits related to health care services *incurred* as a result of an automobile accident on a secondary basis only. Benefits payable under the *Plan* will be coordinated with and secondary to benefits provided or required by any automobile insurance statute (whether or not a no-fault policy is in effect) and/or other automobile insurance.

Coordination of Benefits and Medicare

Active Employees Age 65 or Over

Medicare coverage is secondary to the *Plan* for an active *employee*, age 65 or over, and a *spouse*, age 65 or over, of such active *employee*. *Medicare* is also secondary for any *disabled covered dependents*. *Medicare* coverage, even on a secondary basis, can provide valuable benefits. If you apply when eligible for *Medicare* Part A, there is no premium charge.

In any situation where this *Plan* would have been secondary to *Medicare* had the *Plan participant* enrolled, this *Plan* will not pay for any expenses that otherwise would have been paid under *Medicare* Parts A and/or B regardless of whether or not the *Plan participant* actually enrolled.

Because of this *Medicare* secondary provision, it is important that you have certain information concerning the *Plan* and *Medicare*:

- If you and/or your *spouse* are not presently enrolled in the *Plan*, you and/or your *spouse* may request coverage at any time. However, requested coverage is subject to the *Plan's* normal eligibility and effective date provisions.
- If you and your *spouse* are presently covered under the *Plan*, you may remain covered while you continue active employment unless you request, in writing, that coverage be terminated.
- A person becomes eligible for *Medicare* upon attainment of age 65 if he or she is then qualified for Social Security retirement benefits.
- *Medicare* coverage is divided into two parts. *Medicare* Part A (Hospital) coverage is provided at no cost. *Medicare* Part B (Surgical and Medical) coverage requires payment of a monthly premium.
- To enroll for *Medicare*, contact the nearest Social Security office prior to attainment of age 65. Also, a booklet entitled "Your Medicare Handbook" is available from any Social Security office. This booklet is free and provides a detailed description of *Medicare* benefits.

Note: For active *employees,* age 65 or over, and for *spouses,* age 65 or over, federal law requires that *Medicare* be a secondary payer and pay after an *employer*-sponsored medical plan, under which these active *employees* and *spouses* are covered. However, an active *employee,* age 65 or over, has the option of rejecting the *employer*-sponsored medical plan with the result that *Medicare* becomes the primary payer. Rejection of this *employer*-sponsored medical plan should be submitted, in writing, to the Human Resources Department. If you have elected *Medicare* as your primary form of health insurance, you are excluded from coverage under this *Plan.*

Carefully review your options when you become eligible for *Medicare* Part B. Persons who do not elect *Medicare* Part B when first eligible, and who later wish to obtain *Medicare* Part B coverage, must usually serve a waiting period and are charged an increased monthly premium. The waiting period and the increased premium, however, are waived for all persons during the period their *Medicare* coverage is secondary to this *Plan.*

If *Medicare* coverage for you or your *spouse* will be (or is now) secondary to the *Plan*, and if you wish to reject or delay *Medicare* Part B, contact the Social Security Administration as early as possible.

Plan Participants with Permanent Kidney Failure

Medicare is a secondary payer to an *employer's* group health plan for up to 30 months for beneficiaries who have *Medicare* solely because of permanent kidney failure. At the end of the 30-month period, *Medicare* becomes the primary payer until your *Medicare* coverage for permanent kidney failure ends. For further information check with your nearest Social Security office or the *Medicare* insurance carrier in your area.

Plan Participants Under Age 65 with Disabilities

Medicare may be a secondary payer for people under age 65 who are entitled to *Medicare* based on *disability* and who have large group health plan coverage. For further information check with your nearest Social Security office or the *Medicare* insurance carrier in your area.

Medicare and Limiting Charges

When *Medicare* is the primary or secondary payer for a *Plan participant,* the *Plan* specifically limits coverage of *Medicare* balance bills to the limiting charge amounts. Generally, a *provider* who has not accepted assignment may not charge more than 115% of the *Medicare*-approved amount for services provided January 1, 1992, or later. This is considered the limiting charge.

Recovery of Overpayments

Occasionally, health care benefits are paid more than once, are paid based on improper billing, or are not paid according to the *Plan's* terms, conditions, limitations, or exclusions. Whenever the *Plan* pays health care benefits exceeding the amount of benefits payable under the terms of the *Plan*, the *Plan Administrator* and/or the *claims administrator* has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from the *Plan participant* on whose behalf such payment was made.

A *Plan participant*, a health care service *provider*, another health benefit plan, an insurer, or any other person or entity who receives a payment for health care expenses exceeding the amount of benefits payable under the terms of the *Plan* or on whose behalf such payment was made, shall return the amount of such erroneous payment to the *Plan* within 30 days of discovery or demand. The *Plan Administrator* and/or the *claims administrator* shall have no obligation to secure payment for the health care expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another health care expense. The *Plan Administrator* and/or the *claims administrator* shall have the discretion to choose who will repay the *Plan* for an erroneous payment and such payment shall be reimbursed in a lump sum or deducted from future claims presented for processing.

Health care service *providers* and any other person or entity accepting payment from the *Plan*, in consideration of such payments, agree to be bound by the terms of this *Plan* and agree to submit claims for reimbursement in strict accordance with their states' health care practice acts, ICD-9 or CPT standards, *Medicare* guidelines, HCPCS standards, or other standards approved by the *Plan Administrator* or insurer. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the *Plan* within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If court action is necessary to recover any erroneous payment, the *Plan* shall be entitled to recover its litigation cost and actual attorneys' fees incurred.

Right to Receive and Release Necessary Information

For the purpose of determining the applicability of, and implementing the terms of, this COB provision or any provision of similar purpose of any other plan, this *Plan* may, without the consent of or notice to any person, release to or obtain from any insurance company, or other organization or individual, any information with respect to any person that the *Plan* deems to be necessary for such purposes. Any person claiming benefits under this *Plan* shall furnish to the *Plan* such information as may be necessary to implement this provision.

Subrogation

This *Plan* reserves all rights of subrogation. This means that the *Plan* has the right to recover its previously paid benefit payments from any award, settlement, or damages that you or your *covered dependents* may receive or to which you may become entitled. It also means that the *Plan* has the right to assert your rights (take action on your behalf) to obtain an award, settlement, or damages. The most common situations involving subrogation are auto accidents, but others include medical malpractice, *accidental injuries,* negligence, defective products, etc.

IMPORTANT NOTE: You must immediately notify the *claims administrator* whenever an *injury* or *illness* arises as a result of an accident, a person's negligence, or any other circumstance that may entitle you or your *covered dependent* to an award, settlement, or damages.

Right to Recover Benefit Payments

The *Plan* shall have the first lien upon all awards, settlements, or damages subject to its subrogation or reimbursement rights listed below. This lien shall be in the amount of benefits provided or the amount of benefits that will be provided under the *Plan,* plus the reasonable expenses, including attorneys' fees, to enforce the *Plan's* rights.

- The *Plan* has the right to recover payment for benefits paid by the *Plan* to or on behalf of you or your *covered dependents* from any award, settlement, or damages that you or your *covered dependents* may become entitled to or receive (including amounts paid or payable to a trust established on your or your *covered dependents'* behalf) as a result of an accident, a person's fault or negligence, or any other circumstance under which you or your *covered dependent* has the right to recover from any other party.
- The *Plan* may recover its benefit payments for any type of benefit that may be paid by the *Plan*, such as medical, dental, vision, mental, *disability,* supplemental accident, or accidental death or dismemberment benefits.
- An "award, settlement, or damages" includes any award, settlement, damages (whether equitable, legal, compensatory, etc.), compensation, benefits, or any other payment of any kind. The amount may be paid by formal court award, informal compromise, redemption agreement, application for benefits, or otherwise. The amount also may be paid in a lump sum, installment, or annuity payments (such as income replacement). The *Plan* has the right to recover from all of these amounts.
- An "award, settlement, or damages" includes amounts of any type, kind, nature, or character, regardless of whether the amount identifies or covers the *Plan's* benefit payments, otherwise relates to medical benefits, or is specifically limited to certain kinds of damages or payments. For example, if you receive an award, settlement, or damages solely for pain and suffering, the *Plan* is still entitled to recover its benefit payments from such amount. In addition, attorneys' fees or any other costs associated with the amount will not reduce the amount of the *Plan's* reimbursement. **This *Plan* has the first priority to recover from your award, settlement, or damages**. The *Plan's* first priority lien also will apply regardless of whether you or your *covered dependent* is or was made whole from the

award, settlement, or damages, whether before or after the *Plan's* subrogation recovery. This *Plan* precludes the operation of the "made-whole" and "common fund" doctrines.

- Your "right to recover" from any other party means that you or your *covered dependent* has the right to recover damages or expenses from another party, such as an individual, partnership, corporation, government, or other entity, as well as against that party's respective insurance carriers or governmental fund, for causing an *injury* or *illness* to you or your *covered dependent* or otherwise with respect to any *injury* or *illness incurred* by you or your *covered dependents*. This right to recover from any other party also includes your own insurance carrier, such as your automobile insurance, automobile no-fault coverage, homeowners insurance, personal accident coverage, general liability insurance, or life insurance carrier. It also includes a second medical insurance or other non-insured medical or other coverage. It also includes uninsured motorist coverage or programs. The *Plan* has the right to recover from any of these parties, or any other parties, in connection with your *illness* or *injury*.

In the event you or your *covered dependent* is entitled to or receives an award, settlement, or damages from any party (which includes the other party's or your own insurance carrier or coverage), the *Plan* has the first lien upon the award, settlement, or damages and must be reimbursed for its benefit payments made to you or your *covered dependent,* or on your behalf. The *Plan's* first lien supersedes any right that the *Plan participant* may have to be "made whole." In other words, the *Plan* is entitled to the right of first reimbursement out of any award, settlement, or damages the *Plan participant* procures or may be entitled to procure regardless of whether the *Plan participant* has received compensation for any of his or her damages or expenses, including any of his or her attorneys' fees or costs. The *Plan* has a right to any full or partial recovery of any and all amounts paid by it on the *Plan participant's* behalf. The *Plan* will be accorded priority over the *Plan participant* as to any funds recovered. Additionally, the *Plan's* right of first reimbursement will not be reduced for any reason, including attorneys' fees, costs, comparative negligence, limits of collectibility or responsibility, or otherwise. As a condition to receiving benefits under the *Plan,* the *Plan participant* agrees that acceptance of benefits is constructive notice of this provision.

Reimbursement to the *Plan* must be made immediately upon entitlement or receipt of any award, settlement, or damages. The *Plan* will charge interest at a reasonable rate for any delay in reimbursement.

Right to Assert Claims on Your Behalf

The *Plan* has the right, if it so chooses, to assert rights on your behalf to obtain an award, settlement, or damages. Specifically, through subrogation, the *Plan* is entitled to all claims, demands, actions, and rights of recovery that you or your *covered dependent* may have against or from any party (including the other party's or your own insurance carriers) to the extent of the *Plan's* benefit payments. In addition, this *Plan* is entitled to attorneys' fees incurred in asserting rights on your behalf.

The *Plan* does not require you or your *covered dependents* to pursue a claim against another party. However, as stated above, the *Plan* reserves the right to directly pursue recovery against another party on your behalf, should you or your *covered dependent* elect not to pursue an award, settlement, or damages against or from a party.

Miscellaneous Subrogation

This *Plan* is a self-insured plan governed by the Employee Retirement Income Security Act (ERISA), a federal statute that preempts all state law limitations concerning subrogation. Accordingly, state laws pertaining to subrogation do not apply under this *Plan*.

You, your *covered dependents,* your attorneys, or anyone acting on your behalf legally cannot do anything to prejudice the rights of the *Plan* in the exercise of its subrogation rights to recover from, or assert your rights to obtain, an award, settlement, or damages.

The *Plan's* subrogation rights also extend to the guardian or estate of you and your *covered dependents*. The *Plan's* subrogation provisions will apply without limitation by the *Plan's* coordination of benefits provisions, unless the COB provisions would result in a greater recovery for the *Plan.*

Participant Agreement Obligation

As a condition to participating in the *Plan* and receiving benefits under the *Plan,* you and your *covered dependents* agree to be bound by all of the *Plan's* provisions, including, but not limited to, the *Plan's* subrogation provisions. The *Plan,* upon satisfactory review of a claim, will make benefit payments on a claim on the condition that you or your *covered dependent,* upon entitlement or receipt of any award, settlement, or damages, will fully reimburse the *Plan* for the *Plan's* benefit payments and for expenses (including attorneys' fees and costs of suit, regardless of an action's outcome) incurred by the *Plan* in collecting this amount.

As a precondition to receiving benefits under the *Plan,* you and your *covered dependents* must enter into agreement with the *Plan* to reimburse the *Plan* for its benefit payments from any award, settlement, or damages pursuant to the *Plan's* subrogation provisions. In this agreement, you also must agree to assign direct payment to the *Plan* from any award, settlement, or damages to the extent of the *Plan's* benefit payments. You and your *covered dependents* also otherwise must sign and deliver any and all instruments, papers, and reimbursement agreements required by the *Plan* necessary for the *Plan's* reimbursement right. You and your *covered dependents* also are required to do whatever is requested or necessary in order to fully execute and to fully protect all the *Plan's* rights and to do nothing that would interfere with or diminish those rights. Further, you and your *covered dependents* must notify the *Plan* in writing of any proposed settlement and obtain the *Plan's* written consent before signing any release or agreeing to any settlement. In any event, the *Plan's* benefit payments for any current or historical claims under the *Plan* on your behalf will be deemed to be the equivalent of you or your *covered dependent* entering into an agreement to reimburse the *Plan* and otherwise signing and delivering any instruments and papers as required by the *Plan.*

In the event that you or your *covered dependents* fail to enter into the foregoing agreement, or otherwise to comply with such requests, the *Plan* is entitled to withhold or deny benefits otherwise due under the *Plan* until you do so.

When a Plan Participant Retains an Attorney

A *Plan participant* or his or her attorney who receives any recovery (whether by award, settlement, damages, compromise, or otherwise) has an absolute obligation to immediately tender the recovery to the *Plan* under the terms of this provision. A *Plan participant* or his or her attorney who receives any such recovery and does not immediately tender the recovery to the *Plan* will be deemed to hold the recovery in constructive trust for the *Plan*, because the *Plan participant* or his or her attorney is not the rightful owner of the recovery and should not be in possession of the recovery until the *Plan* has been fully reimbursed.

When a Plan Participant Does Not Comply

When a *Plan participant* does not comply with the provisions of this section, the *claims administrator* shall have the authority, at its sole discretion, to deny payment of any claims for benefits by the *Plan participant* and to deny or reduce future benefits payable (including payment of future benefits for other *injuries* or *illnesses*) under the *Plan* by the amount due as reimbursement to the *Plan*. The *claims administrator* may also, at its sole discretion, deny or reduce future benefits (including future benefits for other *injuries* or *illnesses*) under any other group benefits plan maintained by the *Plan Sponsor*. The reductions will equal the amount of the required reimbursement. If the *Plan* must bring an action against a *Plan participant* to enforce this provision, then that *Plan participant* agrees to pay the *Plan's* attorneys' fees and costs, regardless of the action's outcome.

PLAN LIMITATIONS AND PROVISIONS

Deductibles		
	PPO	**Non-PPO**
Per Individual	$300 per calendar year	$1,000 per calendar year
Per Family	$750 per calendar year	$3,000 per calendar year

Out-of-Pocket Maximums		
	PPO	**Non-PPO**
Per Individual	$1,500 per calendar year	$5,000 per calendar year
Per Family	$3,500 per calendar year	$10,000 per calendar year

Including the Deductible

Excludes:

- Amounts over the usual, customary, and reasonable charges (UCR)
- Penalties incurred for non-compliance with the Pre-Certification of Inpatient Services Program
- Penalties incurred for non-compliance with the Pre-Certification of Outpatient Services Program
- Coinsurance for inpatient and/or outpatient mental health care and/or substance abuse care
- Coinsurance for spinal manipulation and related services (chiropractic care)
- Co-payments or coinsurance for prescription drugs
- Flat dollar co-payments
- Exclusions and Limitations — Medical

Remember, to obtain specific benefits you must comply with the Pre-Certification Programs as outlined in the HEALTH MANAGEMENT SERVICES AND SPECIAL PROVISIONS section.

Lifetime Maximums	
Per Individual	**$1,000,000 per Plan Participant** All Services • While Enrolled in the Plan
	$25,000 for all Substance Abuse Care
	$2,500 for Services Related to Temporomandibular Joint Syndrome

Annual Maximums (Per Calendar Year)	
Per Individual	30 days or visits for all Mental Health and Substance Abuse Care combined
	$500 for Spinal Manipulation and Related Services (Chiropractic Care) and Osteopathic Manipulation Therapy
	$1,000 for Services Related to Temporomandibular Joint Syndrome
	60 days of Extended Skilled Nursing Facility Care
	60 Home Health Care Nursing Visits
	60 Nursing Care Visits
	12 visits and $40 per visit for Hospice Care Bereavement Counseling (for covered survivors only)
	$300 for Preventative Care

Other Maximums	
Per Individual	$1,000 per occurrence for Ground Ambulance
	$7,500 per occurrence for Air Ambulance

Pre-Existing Condition Exclusion

Pre-Existing Condition

A *pre-existing condition* is a medical condition (whether physical or mental) of an *employee* or a *covered dependent*, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received, by or from a health care *provider* or practitioner duly licensed to provide such care under applicable state law and operating within the scope of practice authorized by such state law, within the 6-month period ending on his or her *enrollment date*. Pregnancy is not considered a *pre-existing condition*.

Exclusion Period

Charges *incurred* by an *employee* or a *covered dependent* in connection with a *pre-existing condition* are covered to a maximum of the first $2,000 of benefit payments until 12 months after his or her *enrollment date.* After those 12 months, *covered charges incurred* in connection with a *pre-existing condition* are payable as any other *covered charge.*

Enrollment Date

If you enroll when first eligible (as a new *employee*), your *enrollment date* is the first day of the 90-day waiting period. If you do not enroll when first eligible, your *enrollment date* is the first day of coverage. For example, if you are hired on January 1, 2005, and subject to the 90-day waiting period, your *enrollment date* is January 1, 2005 (your hire date), assuming you immediately enroll in the *Plan* after your waiting period. (If you do not immediately enroll, your *enrollment date* will be your first day of coverage under the *Plan*; see **Late and Special Enrollment** below.) An *employee* and a *covered dependent* may have different *enrollment dates*.

Newborns and Adopted Children

The *Plan* will not apply its *pre-existing condition* exclusion to a child who is enrolled in the *Plan* within 31 days from the date of birth. The *Plan* will not apply its *pre-existing condition* exclusion to a child who later becomes covered under the *Plan*, provided the child was enrolled within 31 days of birth under other

creditable coverage (generally other group health coverage) and the child did not incur a 63-day break in coverage. (See **Creditable Coverage** below.)

The *Plan* will not apply its *pre-existing condition* exclusion to a child who is adopted or placed for adoption before attaining age 18 and who is enrolled in the *Plan* within 31 days of the date of the adoption or placement for adoption. (The *Plan*, however, will apply the exclusion to coverage, if any, before the date of such adoption or placement for adoption.) In the same manner, the *Plan* will not apply its *pre-existing condition* exclusion to an adopted child who later becomes covered under the *Plan* if the child was enrolled under other *creditable coverage* within 31 days of the adoption or placement for adoption and does not subsequently incur a 63-day break in coverage. (See **Creditable Coverage** below.)

When you learn that you or your *covered dependent* is pregnant, you must enroll in the Baby & Me Program during your first trimester or your benefits will be paid at the out-of-network rate, even if services are received in-network. See the Health Management Services and Special Provisions section.

Creditable Coverage

The *Plan's* exclusion period for any *pre-existing condition* that would otherwise apply to an *employee* or *covered dependent* will be reduced by the number of days of his or her *creditable coverage* (generally other group health coverage) as of his or her *enrollment date*. To qualify for this reduction, you must meet the following conditions:

- You must not have incurred a break in coverage of 63 days or more before your *enrollment date*. (The *Plan's* waiting period, therefore, will not cause you to incur a 63-day break in coverage.) For this purpose, a 63-day break in coverage is a 63-day period during all of which the *employee* or *covered dependent* was not covered under any *creditable coverage*. Any waiting period or HMO affiliation period under your *creditable coverage* will not be counted in determining whether you incurred a 63-day break in coverage.
- You must provide the *Plan* with a written certification of your previous *creditable coverage*.
  - Note: You may use successive periods of *creditable coverage* from multiple plans, provided you did not incur an intervening 63-day break in coverage between the *creditable coverages*. See the example under the definition of *"creditable coverage."*
  - If you are unable to obtain a certificate of coverage from a previous plan, you may prove evidence of *creditable coverage* through other documentation. This documentation should establish dates of coverage, any waiting periods, and the type of coverage provided.

By law, you have the right to request a certificate of *creditable coverage* from a prior plan or issuer. Upon your written request, the *Plan* will assist you in obtaining a certificate from any prior plan or issuer, if necessary.

The *Plan* will make a determination regarding your *creditable coverage* within a reasonable time after receiving your certification of coverage (or other documentation). The *Plan* will then issue you a written notice of its determination of any *pre-existing condition* exclusion period that applies to you. The notice will include the basis for the determination, as well as a written explanation of the *Plan's* appeal procedures.

Late and Special Enrollment

If you do not enroll in the *Plan* when first eligible, your *enrollment date* will be the first day of coverage under the *Plan* and not your date of hire.

The *Plan*'s *pre-existing condition* exclusion, therefore, will be applied to you using your first day of coverage under the *Plan*, with the following results:

- Your first day of coverage under the *Plan* will be used to measure the beginning of the *Plan*'s *pre-existing condition* exclusion period.
- Whether you have a *pre-existing condition* will be determined on the basis of whether you received diagnosis or care within the 6-month period ending on your first day of coverage under the *Plan*.
- Your *creditable coverage* will be determined as of your first day of coverage under the *Plan*.

Detailed Description of Plan Limitations

Deductibles

The medical deductibles are the amounts you must pay first each calendar year before this *Plan* pays benefits. The deductibles apply to each *Plan participant* and are listed at the beginning of this section.

The deductible applies to each covered member of a *family*. However, when *family* members *incur* any combination of *covered charges* totaling the *family* deductible in any calendar year (as long as no one person contributes more than his or her individual amount), then the deductible amount is considered satisfied for your entire *family*.

Any payments for *covered charges* that are used to help satisfy the deductible under the PPO portion of the *Plan* are also used to satisfy the deductible under the non-PPO portion of the *Plan,* and vice versa.

If a continuous *hospital confinement* extends past January 1 of any year, only one deductible will be applied. The additional deductible for the new year will be waived for that *confinement*.

Coinsurance

Coinsurance is the amount you must pay for each service before the *Plan* pays benefits. This is a percentage of the eligible benefit that is not covered by the *Plan*. For example, for those benefits for which the *Plan* pays 80%, you are responsible for the 20% coinsurance.

Co-Payments

A co-payment is a flat dollar amount you must pay for certain services before the *Plan* pays benefits. For example, for some services, you must first make a $75 co-payment, and the *Plan* then covers the remainder of your eligible expenses for those services at 80% of the PPO rate or the *UCR.* You must make a $75 co-payment each time you receive those services.

Out-of-Pocket Maximum

This *Plan* has an out-of-pocket maximum feature that helps limit the amount of money you must pay for *covered charges* in any one calendar year. This means that once you have paid the amount specified at the beginning of this section, this *Plan* covers subsequent eligible charges at 100% of the PPO negotiated rate or the *UCR* for the remainder of the calendar year. This feature helps ensure that the amount you must pay out-of-pocket for eligible benefits remains a manageable amount.

Any payments for *covered charges* that are used to help satisfy the out-of-pocket maximum under the PPO portion of the *Plan* are also used to help satisfy the out-of-pocket maximum under the non-PPO portion of the *Plan,* and vice versa.

The out-of-pocket maximum does **not** include items listed in the **Out-of-Pocket Maximums** table at the beginning of this section.

Lifetime and Annual Maximums

The *Plan* provides a cumulative maximum of $1 million for each person covered by the *Plan* while he or she is enrolled in the *Plan*. After the lifetime maximum has been reached for any *Plan participant*, no additional benefits will be paid by this *Plan* for that *Plan participant.*

Once the lifetime maximum for a specific, listed service has been reached, no additional benefits will be paid for that service for that *Plan participant.*

Annual maximums are calculated on a calendar year basis as listed at the beginning of this section. Once the annual maximum for a listed service has been reached, no additional benefits will be paid during the remainder of the calendar year for that service for that *Plan participant.*

Conditions for Providing Benefits

Medical benefits are provided at the PPO negotiated rate when you use a PPO *provider,* or on the basis of *usual, customary, and reasonable (UCR) charges* when you use a non-PPO *provider*. This means that the *Plan* pays the *covered charges* at not more than the PPO negotiated rate (when you use a PPO *provider*) or not more than the *usual, customary, and reasonable charge* (when you use a non-PPO *provider*) for a service, based on what is usually and customarily accepted as payment for the same service within a geographic area, as determined by the *Plan.*

Benefits are provided only for covered services recommended by a *physician* who is a member of the medical staff or acceptable to the *hospital* or *ambulatory care center* selected by the *Plan participant*.

The *Plan participant* may select any *hospital* or *ambulatory care center* that meets the criteria described in the definition of that type of facility. All services furnished are subject to the rules and regulations of the facility.

Usually, benefits under this *Plan* are paid directly to the *provider* rendering the service, unless you provide itemized bills indicating that the charges have been paid in full. In that case, allowable benefits are paid to the *Plan participant*.

In making a decision on claims involving services, supplies, or days of care that are determined by the *Plan* to be medically unnecessary, the *Plan* reserves the right to obtain advisory opinions from consultant(s) of its choice. On reconsideration of denied claims for this reason, the *Plan* further reserves the right to refer such cases to the appropriate peer review committee.

MEDICAL BENEFITS

Overview of PPO/Non-PPO Option

If you use a *provider* who is a member of the PPO network, most benefits are paid at 80% of the PPO negotiated rate, subject to the deductible. You are responsible for the deductible and for the 20% coinsurance.

If you learn that you or your *covered dependent* is pregnant, you must enroll in the Baby & Me Program during your first trimester or your benefits will be paid at the out-of-network rate, even if services are received in-network. See the HEALTH MANAGEMENT SERVICES AND SPECIAL PROVISIONS section.

If you use a *provider* who is **not** a member of the PPO network, most benefits are paid at 50% of *UCR*, subject to the deductible. You are responsible for the deductible, for the 50% coinsurance, **and** for any amounts in excess of the *UCR*.

If you use a *provider* who is not a member of the PPO network, you may be able to have your *covered charges* paid as in-network charges if you are using the out-of-network *provider* solely because you reside a significant distance from the nearest PPO network *provider.* If you desire to have your out-of-network *covered charges* paid as in-network *covered charges,* you need to contact your Human Resources Department prior to incurring any such out-of-network charges. The Human Resources Department will receive a determination for you from the *Plan's* Benefit Committee within a reasonable period of time.

Services that are covered by this *Plan* and are **not available** through a network *provider* are paid at the PPO benefit percentage of *UCR* even when the service is provided by an out-of-network *provider*.

Services provided at a network *hospital*, by an out-of-network *provider,* are paid at the PPO benefit percentage of *UCR*.

Some PPO *hospitals* have arrangements through which the patient is billed more than the actual charges, e.g., per diem or diagnosis-related group (DRG) charges. When this occurs, the *Plan* pays 100% of these excess charges.

You may obtain information regarding participating PPO *providers,* without charge, through the *claims administrator's* website at http://www.umr.com. If you do not have access to a computer at your home, you may access this website at your place of employment. If you have any questions about how to do this, contact *UMR*.

Each *Plan participant* has a free choice of any *physician* or surgeon, and the *physician*-patient relationship shall be maintained. The *Plan participant,* together with his or her *physician,* is ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the *Plan* will pay for all or a portion of the cost of such care. The PPO *providers* are independent contractors; the *Plan,* the *Plan Administrator,* and the *claims administrator* make no warranty as to the quality of care that may be rendered by any PPO *provider.*

Note: In order to receive your maximum allowable benefits, you must comply with the Pre-Certification Programs as outlined in the HEALTH MANAGEMENT SERVICES AND SPECIAL PROVISIONS section.

Schedule of Benefits

The following tables outline your percentage of coverage as provided by this *Plan.* The tables are followed by a more detailed description of specific benefits.

Urgent Care or *Emergency* Services: It is important to remember that, if a *Plan participant* needs medical care for a condition that could seriously jeopardize his or her life, there is no need to contact the *Plan* for prior approval. The *Plan participant* should obtain such care without delay and follow the rules described in HEALTH MANAGEMENT SERVICES AND SPECIAL PROVISIONS.

Hospital Inpatient Services		
	PPO	***Non-PPO***
Standard Room and Board and Ancillary	80% of PPO rate for Semi-Private Room, subject to deductible	50% of UCR for Semi-Private Room, subject to deductible
Extended Skilled Nursing Facility, Room and Board and Ancillary	80% of PPO rate, subject to deductible and maximum	50% of UCR, subject to deductible and maximum
	Must follow hospital confinement of at least 3 days and be within 14 days of discharge.	
Intensive Care Room and Board	80% of PPO Intensive Care Rate, subject to deductible	50% of UCR of Intensive Care Rate, subject to deductible
Rehabilitation Room and Board	80% of PPO rate for Semi-Private Room, subject to deductible	50% of UCR for Semi-Private Room, subject to deductible
Private Room	80% of PPO rate, subject to deductible	50% of UCR, subject to deductible
	Only if medically necessary.	
Personal Items	Not Covered	Not Covered

Hospital Newborn Care		
	PPO	***Non-PPO***
Newborn Nursery and Ancillary	80% of PPO rate, subject to deductible	50% of UCR, subject to deductible
Neo-Natal Room and Board and Ancillary	80% of PPO rate, subject to deductible	50% of UCR, subject to deductible
Birthing Center	80% of PPO rate, subject to deductible	50% of UCR, subject to deductible
A Plan participant must enroll in the Baby & Me Program during the first trimester of pregnancy, or benefits will be paid at the out-of-network rate, even if services are received in-network.		

Mental Health and Substance Abuse Inpatient, Partial Hospitalization, and Intensive Outpatient Services		
	PPO	***Non-PPO***
Mental Health Care — Room and Board and Ancillary	80% of PPO rate for Semi-Private Room, subject to deductible and maximum	50% of UCR for Semi-Private Room, subject to deductible and maximum
Substance Abuse Care — Room and Board and Ancillary	80% of PPO rate for Semi-Private Room, subject to deductible and maximums	50% of UCR for Semi-Private Room, subject to deductible and maximums
Mental Health Care — Partial Hospitalization/Intensive Outpatient	50% of PPO rate for Semi-Private Room, subject to deductible and maximum	50% of UCR for Semi-Private Room, subject to deductible and maximum
	1 day equal to 1 inpatient day.	

Mental Health and Substance Abuse Inpatient, Partial Hospitalization, and Intensive Outpatient Services		
	PPO	***Non-PPO***
Substance Abuse Care — Partial Hospitalization/Intensive Outpatient	50% of PPO rate for Semi-Private Room, subject to deductible and maximums	50% of UCR for Semi-Private Room, subject to deductible and maximums
	1 day equal to 1 inpatient day.	

Providers' In-Hospital Services		
	PPO	***Non-PPO***
Provider Hospital Visit	80% of PPO rate, subject to deductible	50% of UCR, subject to deductible
Mental Health Hospital Visit	80% of PPO rate, subject to deductible and maximum	50% of UCR, subject to deductible and maximum
Substance Abuse Hospital Visit	80% of PPO rate, subject to deductible and maximums	50% of UCR, subject to deductible and maximums
Newborn Visit	80% of PPO rate, subject to deductible	50% of UCR, subject to deductible

Surgical Inpatient Services		
	PPO	***Non-PPO***
Primary Surgeon	80% of PPO rate, subject to deductible	50% of UCR, subject to deductible
Pain Management	80% of PPO rate, subject to deductible	50% of UCR, subject to deductible
Assistant Surgeon	80% of PPO rate, subject to deductible	50% of UCR, subject to deductible
Anesthesia	80% of PPO rate, subject to deductible	50% of UCR, subject to deductible
TMJ Surgery	80% of PPO rate, subject to deductible and maximums	50% of UCR, subject to deductible and maximums
Dental Surgery — Non-Accident	80% of PPO rate, subject to deductible	50% of UCR, subject to deductible
	For impacted teeth only.	

Surgical Outpatient Services		
	PPO	***Non-PPO***
Primary Surgeon	80% of PPO rate, subject to deductible	50% of UCR, subject to deductible
Pain Management	80% of PPO rate, subject to deductible	50% of UCR, subject to deductible
	Requires Pre-Certification from UMR.	
Assistant Surgeon	80% of PPO rate, subject to deductible	50% of UCR, subject to deductible
Anesthesia	80% of PPO rate, subject to deductible	50% of UCR, subject to deductible

Surgical Outpatient Services		
	PPO	***Non-PPO***
TMJ Surgery	80% of PPO rate, subject to deductible and maximums	50% of UCR, subject to deductible and maximums
Dental Surgery — Non-Accident	Not Covered	Not Covered

Professional Interpretation Services Inpatient and Outpatient		
	PPO	***Non-PPO***
Pathologist Fee	80% of PPO rate, subject to deductible	50% of UCR, subject to deductible
Radiologist Fee	80% of PPO rate, subject to deductible	50% of UCR, subject to deductible
Diagnostic Testing — Interpretation Fee	80% of PPO rate, subject to deductible	50% of UCR, subject to deductible

Emergency Room Services		
	PPO	***Non-PPO***
Emergency Room — Accident — Facility	80% of PPO rate after $75 co-payment, subject to deductible (co-payment waived if admitted)	80% of UCR after $75 co-payment, subject to deductible (co-payment waived if admitted)
Non-Emergency Use	80% of PPO rate after $100 co-payment, subject to deductible	50% of UCR after $100 co-payment, subject to deductible
Emergency Room — Illness — Facility	80% of PPO rate after $75 co-payment, subject to deductible (co-payment waived if admitted)	80% of UCR after $75 co-payment, subject to deductible (co-payment waived if admitted)
Non-Emergency Use	80% of PPO rate after $100 co-payment, subject to deductible	50% of UCR after $100 co-payment, subject to deductible
Emergency Room — Accident — Physician or Other Provider	80% of PPO rate, subject to deductible	80% of UCR, subject to deductible
Emergency Room — Illness — Physician or Other Provider	80% of PPO rate, subject to deductible	80% of UCR, subject to deductible

Outpatient Facility Fees		
	PPO	***Non-PPO***
Outpatient Surgery/Surgery Center — Facility Fee only	80% of PPO rate, subject to deductible	50% of UCR, subject to deductible
	Requires Pre-Certification from UMR.	
Clinic Visit — Facility Fee only	80% of PPO rate, subject to deductible	50% of UCR, subject to deductible
Outpatient Hospital Services/ Ambulatory Care Center	80% of PPO rate, subject to deductible	50% of UCR, subject to deductible
Pre-Admission Testing	80% of PPO rate, subject to deductible	50% of UCR, subject to deductible
	Within 5 days of surgery.	

Outpatient Diagnostic Services		
	PPO	***Non-PPO***
Diagnostic Laboratory	80% of PPO rate, subject to deductible	50% of UCR, subject to deductible
Diagnostic Testing	80% of PPO rate, subject to deductible	50% of UCR, subject to deductible
Diagnostic X-ray	80% of PPO rate, subject to deductible	50% of UCR, subject to deductible
PET Scan	80% of PPO rate, subject to deductible	50% of UCR, subject to deductible
CAT Scan	80% of PPO rate, subject to deductible	50% of UCR, subject to deductible
	Requires Pre-Certification from UMR.	
Magnetic Resonance Imaging	80% of PPO rate, subject to deductible	50% of UCR, subject to deductible

Outpatient Therapy Services		
	PPO	***Non-PPO***
Biofeedback — Medical	Not Covered	Not Covered
Cardiac Rehabilitation	80% of PPO rate, subject to deductible	50% of UCR, subject to deductible
	Requires Pre-Certification from UMR.	
Chemotherapy	80% of PPO rate, subject to deductible	50% of UCR, subject to deductible
	Requires Pre-Certification from UMR.	
Dialysis	80% of PPO rate, subject to deductible	50% of UCR, subject to deductible
Intravenous Therapy	80% of PPO rate, subject to deductible	50% of UCR, subject to deductible
Occupational Therapy	80% of PPO rate, subject to deductible	50% of UCR, subject to deductible
	Requires Pre-Certification from UMR.	
Osteopathic Manipulation Therapy	80% of PPO rate, subject to deductible and maximum	50% of UCR, subject to deductible and maximum
Physical Therapy	80% of PPO rate, subject to deductible	50% of UCR, subject to deductible
	Requires Pre-Certification from UMR.	
Radiation Therapy	80% of PPO rate, subject to deductible	50% of UCR, subject to deductible
Speech Therapy	80% of PPO rate, subject to deductible	50% of UCR, subject to deductible
	Requires Pre-Certification from UMR.	
Vision Therapy	Not Covered	Not Covered

Medical Benefits

Doctor's Office Services		
	PPO	***Non-PPO***
Allergy Care (extracts, serums, injections)	80% of PPO rate, subject to deductible	50% of UCR, subject to deductible
	Must be medically necessary.	
Injections	80% of PPO rate, subject to deductible	50% of UCR, subject to deductible
Office Extras	80% of PPO rate, subject to deductible	50% of UCR, subject to deductible
Office Visit	80% of PPO rate, subject to deductible	50% of UCR, subject to deductible
	Includes urgent care visits billed by a physician.	
TMJ-Related Services	80% of PPO rate, subject to deductible and maximums	50% of UCR, subject to deductible and maximums

Chiropractic Services		
	PPO	***Non-PPO***
Chiropractic Visit	80% of PPO rate, subject to deductible and maximum	50% of UCR, subject to deductible and maximum
Chiropractic X-ray	80% of PPO rate, subject to deductible and chiropractic maximum	50% of UCR, subject to deductible and chiropractic maximum

Outpatient Mental Health and Substance Abuse Services		
	PPO	***Non-PPO***
Biofeedback — Mental Health	Not Covered	Not Covered
Mental Health Office Visit — Outpatient	50% of PPO rate, subject to deductible and maximum	50% of UCR, subject to deductible and maximum
Mental Health Testing and Evaluation	50% of PPO rate, subject to deductible and maximum	50% of UCR, subject to deductible and maximum
Social Worker Visit	50% of PPO rate, subject to deductible and maximum	50% of UCR, subject to deductible and maximum
Substance Abuse Visit — Outpatient	Not Covered	Not Covered

Preventative Care Services		
	PPO	***Non-PPO***
Immunizations	100% of PPO rate, subject to maximum, then 80% of PPO rate, subject to deductible	100% of UCR, subject to maximum, then 60% of UCR, subject to deductible
Well Child Care	100% of PPO rate, subject to maximum, then 80% of PPO rate, subject to deductible	100% of UCR, subject to maximum, then 60% of UCR, subject to deductible
Preventative Exam	100% of PPO rate, subject to maximum, then 80% of PPO rate, subject to deductible	100% of UCR, subject to maximum, then 60% of UCR, subject to deductible
Prostate Exam	100% of PPO rate, subject to maximum, then 80% of PPO rate, subject to deductible	100% of UCR, subject to maximum, then 60% of UCR, subject to deductible

Preventative Care Services		
	PPO	***Non-PPO***
GYN Exam	100% of PPO rate, subject to maximum, then 80% of PPO rate, subject to deductible	100% of UCR, subject to maximum, then 60% of UCR, subject to deductible
Mammogram	First one per calendar year: 100% of PPO rate, regardless of diagnosis Subsequent: 100% of PPO rate, subject to maximum, then 80% of PPO rate, subject to deductible	100% of UCR, subject to maximum, then 60% of UCR, subject to deductible
Pap Test	100% of PPO rate, subject to maximum, then 80% of PPO rate, subject to deductible	100% of UCR, subject to maximum, then 60% of UCR, subject to deductible
Eye Exam	Not Covered	Not Covered
Hearing Exam	100% of PPO rate, subject to maximum, then 80% of PPO rate, subject to deductible	100% of UCR, subject to maximum, then 60% of UCR, subject to deductible
Preventative Lab	100% of PPO rate, subject to maximum, then 80% of PPO rate, subject to deductible	100% of UCR, subject to maximum, then 60% of UCR, subject to deductible
Lab — Lipid Profile	100% of PPO rate, subject to maximum, then 80% of PPO rate, subject to deductible	100% of UCR, subject to maximum, then 60% of UCR, subject to deductible
Lab — Hemoccult	100% of PPO rate, subject to maximum, then 80% of PPO rate, subject to deductible	100% of UCR, subject to maximum, then 60% of UCR, subject to deductible
Lab — PSA	100% of PPO rate, subject to maximum, then 80% of PPO rate, subject to deductible	100% of UCR, subject to maximum, then 60% of UCR, subject to deductible
Preventative Lab — Pathologist Fee	100% of PPO rate, subject to maximum, then 80% of PPO rate, subject to deductible	100% of UCR, subject to maximum, then 60% of UCR, subject to deductible
Lab — Lipid Profile Pathology	100% of PPO rate, subject to maximum, then 80% of PPO rate, subject to deductible	100% of UCR, subject to maximum, then 60% of UCR, subject to deductible
Lab — Hemoccult Pathology	100% of PPO rate, subject to maximum, then 80% of PPO rate, subject to deductible	100% of UCR, subject to maximum, then 60% of UCR, subject to deductible
Lab — PSA Pathology	100% of PPO rate, subject to maximum, then 80% of PPO rate, subject to deductible	100% of UCR, subject to maximum, then 60% of UCR, subject to deductible
Lab — Pap Pathology	100% of PPO rate, subject to maximum, then 80% of PPO rate, subject to deductible	100% of UCR, subject to maximum, then 60% of UCR, subject to deductible
Preventative X-ray	100% of PPO rate, subject to maximum, then 80% of PPO rate, subject to deductible	100% of UCR, subject to maximum, then 60% of UCR, subject to deductible
Preventative X-ray — Radiologist Fee	100% of PPO rate, subject to maximum, then 80% of PPO rate, subject to deductible	100% of UCR, subject to maximum, then 60% of UCR, subject to deductible

Preventative Care Services		
	PPO	***Non-PPO***
X-ray — Mammogram Radiologist Fee	100% of PPO rate, subject to maximum, then 80% of PPO rate, subject to deductible	100% of UCR, subject to maximum, then 60% of UCR, subject to deductible
Preventative Testing	100% of PPO rate, subject to maximum, then 80% of PPO rate, subject to deductible	100% of UCR, subject to maximum, then 60% of UCR, subject to deductible
Preventative Testing — Interpretation Fee	100% of PPO rate, subject to maximum, then 80% of PPO rate, subject to deductible	100% of UCR, subject to maximum, then 60% of UCR, subject to deductible

Other Services		
	PPO	***Non-PPO***
Ambulance — Air Transportation	80% of PPO rate, subject to deductible and maximum	80% of UCR, subject to deductible and maximum
Ambulance — Ground Transportation	80% of PPO rate, subject to deductible and maximum	80% of UCR, subject to deductible and maximum
Durable Medical Equipment	80% of PPO rate, subject to deductible	50% of UCR, subject to deductible
	Requires Pre-Certification from UMR if over $250.	
Orthotics	80% of PPO rate, subject to deductible	50% of UCR, subject to deductible
	Requires Pre-Certification from UMR if over $250. Must be medically necessary.	
Prosthetics	80% of PPO rate, subject to deductible	50% of UCR, subject to deductible
	Requires Pre-Certification from UMR if over $250. Limited to one per lifetime.	
RN and LPN Services — Outpatient	80% of daily charges, subject to deductible and maximum	50% of daily charges, subject to deductible and maximum
Home Health Care Services	80% of PPO rate, subject to deductible and maximum	50% of UCR, subject to deductible and maximum
	Requires Pre-Certification from UMR.	
Hospice	80% of PPO rate, subject to deductible and maximums for bereavement counseling	50% of UCR, subject to deductible and maximums for bereavement counseling
	Requires Pre-Certification from UMR.	

Second Surgical Opinion Services		
	PPO	***Non-PPO***
Office Visit For Second Surgical Opinion — Confirmed	100% of PPO rate	100% of UCR
Office Visit For Second Surgical Opinion — Non-Confirmed	100% of PPO rate	100% of UCR

Other Miscellaneous Services		
	PPO	***Non-PPO***
Miscellaneous Covered Expenses	80% of PPO rate, subject to deductible	50% of UCR, subject to deductible
Behavioral Modification Programs	Not Covered	Not Covered
Dental Service — Accidental Injury	80% of PPO rate, subject to deductible	50% of UCR, subject to deductible
Medical Records Reimbursement	100% of charges	100% of charges
Sleep Disorder Clinic	50% of PPO rate, subject to deductible	50% of UCR, subject to deductible
	Requires Pre-Certification from UMR. Limited to one per lifetime.	

Prescription Drugs	
Prescription Drug Card — Generic	100% after $8 co-payment; maximum 30-day supply
Prescription Drug Card — Brand Name, Generic Available	100% after co-payment amounting to the $8 generic co-payment plus the difference in cost between generic and brand name; maximum 30-day supply *Example: Prozac has a generic equivalent named Fluoxetine* *Prozac costs $92 for a 30-day supply* *Fluoxetine costs $18 for a 30-day supply* *Member would pay $8 plus the $74 difference in price between brand and generic for a total of $82.*
Prescription Drug Card — Brand Name, No Generic Available	80%; Plan participant pays a minimum of $20 and a maximum of $40; maximum 30-day supply
Prescription Drug Mail Service — Generic	100% after $20 co-payment; maximum 90-day supply
Prescription Drug Mail Service — Brand Name, Generic Available	100% after co-payment amounting to the $20 generic co-payment plus the difference in cost between generic and brand name; maximum 90-day supply *Example: Prozac has a generic equivalent named Fluoxetine* *Prozac costs $256 for a 90-day supply* *Fluoxetine costs $53 for a 90-day supply* *Member would pay $20 plus the $203 difference in price between brand and generic for a total of $223.*
Prescription Drug Mail Service — Brand Name, No Generic Available	80%; Plan participant pays a minimum of $50 and a maximum of $80; maximum 90-day supply

Replacement of Organs/Tissues		
	Center of Excellence	***Non-Center of Excellence***
NOTE: A Center of Excellence is a facility that has entered into an agreement through a national organ transplant network to render approved transplant services, to which Lexington Precision Corporation has access. The Center of Excellence facility will be determined by Lexington Precision Corporation and may or may not be located near the geographic area where you reside.		
Transplant Procedure	80% of negotiated rate, subject to deductible	Not Covered

Replacement of Organs/Tissues		
	Center of Excellence	***Non-Center of Excellence***
Organ Procurement and Acquisition	80% of negotiated rate, subject to deductible	Not Covered
Transportation of Recipient to Transplantation	80% of negotiated rate, subject to deductible	Not Covered

Detailed Description of Medical Benefits

Hospital Inpatient Benefits

Inpatient Care: A *Plan participant* who is admitted to a *hospital* as an inpatient is entitled to benefits for *hospital* services. Benefits are paid according to the **SCHEDULE OF BENEFITS**, to include all types of room and board per *confinement*, unless otherwise excluded by the *Plan*.

In order for inpatient care (including partial hospitalization programs) to be covered as a benefit of this *Plan*, the service must be consistent with and *medically necessary* in the diagnosis and treatment of the patient's condition. Also, in order to receive the maximum benefits allowed, the hospitalization must be determined to be necessary and certified by *UMR* through Pre-Certification of Inpatient Services. Failure to follow the Pre-Certification of Inpatient Services steps may result in your claims being paid at a reduced amount.

The following **inpatient care** charges are covered:

- Charges for semi-private room and board, including bed, meals, special diets, and general nursing services. Private rooms will be covered only if *medically necessary*.
- Charges for the use of an operating room, delivery room, and recovery room.
- Charges for the use of an observation room in excess of 23 hours.
- Charges for *hospital* services in *intensive care units* and *cardiac care units.*
- Charges for anesthetic materials.
- Charges for administration of anesthetics when administered by an employee of the *hospital* as a regular *hospital* service or through approved contractual arrangements.
- Charges for dressings, bandages, casts, and splints.
- Charges for X-rays, laboratory services, pathological services, and machine diagnostic tests.
- Charges for oxygen and other respiratory therapy, as provided by the *hospital.*
- Charges for physio-therapy, hydrotherapy, and other rehabilitative services, as provided by the *hospital.*

If a *Plan participant* seeks *emergency* services through a *hospital's emergency* room and is admitted as a *hospital* inpatient at that time due to that *emergency*, coverage for that inpatient *confinement* will be provided as an inpatient *hospital* benefit, not as an *emergency* room benefit.

Extended Skilled Nursing Facility: In lieu of *hospital confinement*, benefits are provided for services rendered by an *extended skilled nursing facility* according to the **SCHEDULE OF BENEFITS** and **PLAN LIMITATIONS AND PROVISIONS**.

The *medical services* and supplies of this benefit are provided under the terms of an approved *extended skilled nursing facility* treatment plan.

Hospital Maternity Care

Under the Newborns' and Mothers' Health Protection Act of 1996, group health plans and health insurance issuers generally may not restrict benefits for any *hospital* length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending *provider,* after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a *provider* obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). You, your *spouse,* or your *covered dependents* are not required to give birth in a *hospital* or to stay in the *hospital* for a fixed period of time following birth.

If your *physician* feels that a longer stay is necessary, you must obtain prior approval from *UMR*. See the PRE-CERTIFICATION OF INPATIENT SERVICES section.

Obstetrical Care – *Hospital:* Benefits are provided for obstetrical care and conditions of pregnancy to the *employee* and *covered dependents* during the period of *hospital confinement*. The payment of obstetrical benefits is determined as of the date the services are rendered. A child becomes a *covered dependent* at birth, provided the child is enrolled in the *Plan* within 31 days of the date of birth. *Hospital* benefits are paid according to the SCHEDULE OF BENEFITS.

Newborn Care: Benefits are provided for inpatient examination of a newborn infant during the period of *hospital confinement*. The *Plan* covers charges for circumcision at the time of birth.

Obstetrical Services: Benefits are provided for obstetrical services rendered by the *physician* in charge of the case or by another licensed *provider*, including services customarily rendered as prenatal and postnatal care. Benefits are also payable for prenatal care, delivery services, and postnatal care rendered by a Certified Nurse Midwife (CNM). Benefits for obstetrical services are provided to the *employee* and *covered dependents*.

Birthing Center: Benefits are also provided for maternity care provided at a *birthing center.*

It is the responsibility of the *employee* to obtain the appropriate form from the Human Resources Department and add the baby to the *Plan* within 31 days of the child's birth.

Mental Health and Substance Abuse Inpatient, Partial Hospitalization, and Intensive Outpatient Services

Mental Health Inpatient, Partial Hospitalization, and Intensive Outpatient Services

Benefits to a *Plan participant* who is admitted to a *mental health treatment facility,* or to a *hospital* for *mental health* care, are limited as outlined in PLAN LIMITATIONS AND PROVISIONS.

Benefits are provided for inpatient, partial hospitalization, and intensive outpatient *mental health* care only at a licensed facility.

Inpatient *mental health* care charges do not apply to the out-of-pocket maximum. Even if the out-of-pocket maximum is reached, the *Plan* continues to pay according to the SCHEDULE OF BENEFITS until the maximum benefits are reached.

Substance Abuse Inpatient, Partial Hospitalization, and Intensive Outpatient Services

Benefits to a *Plan participant* who is admitted to a *substance abuse treatment facility,* or to a *hospital* for *substance abuse* care, are limited as outlined in PLAN LIMITATIONS AND PROVISIONS.

Benefits are provided for inpatient, partial hospitalization, and intensive outpatient *substance abuse* care only at a licensed facility.

Inpatient *substance abuse* care charges do not apply to the out-of-pocket maximum. Even if the out-of-pocket maximum is reached, the *Plan* continues to pay according to the SCHEDULE OF BENEFITS until the maximum benefits are reached.

Providers' In-Hospital Services

The *Plan* provides benefits according to the SCHEDULE OF BENEFITS for the following professional services performed by a licensed *provider*:

In-*Hospital* Concurrent Medical Care: Benefits are provided for services rendered concurrently by a *provider* other than the attending *physician* when warranted by the need for the skills of a specialist. A patient is eligible for concurrent medical care if he or she has a separate and complicated diagnosis that, if left untreated, would adversely affect his or her prognosis, and if management of the condition requires the skills of a specialist.

In-*Hospital Medical Services:* Benefits are provided for professional services rendered by the attending *provider* while the *Plan participant* is hospitalized. The *Plan* pays benefits for *Plan participants* who receive *medical services,* beginning on the first day of such hospitalization.

Surgical Inpatient and Outpatient Services

Anesthesia Services: Benefits are provided for the administration of spinal, rectal, or local anesthesia, or a drug or other anesthetic agent by injection or inhalation. Benefits are also payable for services rendered by a Certified Registered Nurse Anesthetist (CRNA).

Surgical Assistants: Benefits are provided for a licensed *provider* who actively assists the operating surgeon in the performance of surgical services when the condition of the patient and type of surgical services requires such assistance. Benefits are also provided for services rendered by a licensed surgical *physician's* assistant.

Surgical Services: Benefits are provided for *surgical procedures*, including treatment for fractures and dislocations and routine preoperative and postoperative care.

When more than one *surgical procedure* is performed during the same operative session, the benefit is paid as follows:

- 100% of the applicable PPO or *UCR* rate is considered for calculating the correct *Plan* benefit of the most complex procedure.
- 50% of the applicable PPO or *UCR* rate is considered for calculating the correct *Plan* benefit of each subsequent procedure.

Professional Interpretation Services Inpatient and Outpatient

Benefits are provided for the interpretation of diagnostic tests.

Emergency Room Services

Benefits are provided for:

- *Emergency* room services due to an accident.
  - ♦ However, you will make a higher co-payment if *UMR* determines the charges include a non-emergency use of *emergency* facilities.
- *Emergency* room services due to an *illness*.
  - ♦ However, you will make a higher co-payment if *UMR* determines the charges include a non-emergency use of *emergency* facilities.

Benefits are also provided for the *provider's* charges for surgical or medical care rendered in an *emergency* room.

Outpatient Services

For a *Plan participant* requiring outpatient care, the *Plan* pays the following benefits when provided in an outpatient department of a *hospital* or in an *ambulatory care center*. The following charges are covered according to the SCHEDULE OF BENEFITS.

Outpatient Diagnostic Examinations: Benefits are provided for services such as X-ray examinations, electrocardiograms (EKG), venous Doppler studies, magnetic resonance imaging (MRI), computerized axial tomography (CAT scan), basal metabolism tests, and electroencephalograms (EEG), when the study is directed toward the diagnosis of a definite condition, disease, or *injury.* A CAT scan requires pre-certification from *UMR.*

Outpatient Surgery/*Surgery Center:* Benefits are provided for services administered at a *surgery center,* in an outpatient department of a *hospital,* or in a *physician's* office, including the *physician* and anesthesiologist charges. Outpatient surgeries require pre-certification from *UMR.*

Pre-Admission Testing: Benefits are provided for *pre-admission testing* for expenses *incurred* within 5 days prior to the scheduled surgery.

Outpatient Therapy Services

The following outpatient therapy services are paid according to the SCHEDULE OF BENEFITS.

Cardiac Rehabilitation: Benefits are provided for a *hospital* outpatient department cardiac rehabilitation program. These services require pre-certification from *UMR.*

Chemotherapy Services: Benefits are provided for expenses *incurred* for chemotherapy treatment when prescribed and billed for by a licensed *provider*. These services require pre-certification from *UMR.*

Dialysis: Benefits are provided for kidney dialysis when not reimbursed by *Medicare*.

Intravenous Therapy: Benefits are provided for intravenous therapy.

Occupational Therapy: Benefits are provided for the use of work-related skills to treat or train the physically or emotionally ill, to prevent *disability,* to evaluate behavior, and to restore *disabled* persons to health or to social or economic independence. These services must be performed by a licensed occupational therapist, who evaluates the self-care, work, play, and leisure time task performance skills of well and *disabled* clients of all ages, and plans and implements programs, social activities, and interpersonal activities designed to restore, develop, and maintain the client's ability to accomplish satisfactorily those daily tasks required of his or her specific age and necessary to his or her particular role adjustment. Occupational therapy services require pre-certification from *UMR.*

Physical Therapy: Benefits are provided for rehabilitation concerned with restoration of function and prevention of *disability* following disease, *injury,* or loss of a body part. The therapeutic properties of exercise, heat, cold, electricity, ultraviolet light, and massage may be used to improve circulation, strengthen muscles, encourage return of motion, and train or retrain an individual to perform the activities of daily living. These services must be performed by a licensed physical therapist, who is legally responsible for planning, conducting, and evaluating a physical therapy program for patients referred by a *physician.* Physical therapy services require pre-certification from *UMR.*

Radiation Therapy: Benefits are provided for treatment by X-ray, radium, external radiation, or radioactive isotopes (including the cost of materials unless supplied by a *hospital*), when performed and billed for by the licensed *provider* in charge of the case.

Speech Therapy: Benefits are provided for the evaluation and treatment of *Plan participants* who have voice, speech, language, swallowing, cognitive, or hearing disorders. These services must be performed by a licensed and certified speech therapist. Speech therapy services require pre-certification from *UMR.*

Doctor's Office Services

Outpatient Diagnostic X-ray and Lab: Benefits are provided for diagnostic X-ray, laboratory, and pathological services given in a *physician's* office that are required for the diagnosis of any condition, disease, or *injury,* and that are customarily billed by the *provider* who made such examination.

Chiropractic Services

Benefits are provided for spinal manipulation therapy and related charges, including X-rays. Chiropractic *maintenance care* is not covered. See **Plan Limitations and Provisions** for limitations on chiropractic services.

Chiropractic therapy charges do not apply to the out-of-pocket maximum. Even if the out-of-pocket maximum is reached, the *Plan* continues to pay according to the **Schedule of Benefits** until the maximum benefits are reached.

Outpatient Mental Health Services

Benefits are provided for outpatient *mental health* care by a licensed psychologist, psychiatrist, or *social worker*. See **Plan Limitations and Provisions** for limitations on outpatient *mental health* care.

Outpatient *mental health* care charges do not apply to the out-of-pocket maximum. Even if the out-of-pocket maximum is reached, the *Plan* continues to pay according to the **Schedule of Benefits** until the maximum benefits are reached.

Preventative Care Benefit

Each *Plan participant* is provided an annual preventative care benefit to cover the costs of selected preventative health care tests. The following tests are paid according to the **Schedule of Benefits** and are limited as listed in **Plan Limitations and Provisions**.

- **GYN Exam.**
- **Hearing Exam.**
- **Hemoccult Test.**
- **Immunizations.**
- **Lipid Profile (Cholesterol Exam).**
- **Mammogram Test.**
- **Pap Test.**
- **Preventative Lab.**
- **Preventative Testing.**
- **Preventative X-rays.**
- **Prostate Exam.**
- **PSA (Prostate Specific Antigen) Test.**
- **Well Child Care.**

Other Services

Ambulance Service: Benefits are provided for local professional ambulance service to a *hospital* from your home, or from the scene of an accident or medical *emergency,* to the nearest facility able to treat your condition. These benefits are limited as listed in **Plan Limitations and Provisions**.

- This ambulance service may include regularly scheduled airline, railroad, or air ambulance to the nearest *hospital* qualified to provide the necessary treatment. Benefits are limited as listed in **Plan Limitations and Provisions**.

Durable Medical Equipment: Benefits are provided for *durable medical equipment* approved for rental (or, at the *Plan's* option, purchase). Benefits for *durable medical equipment* are not to exceed the purchase price.

- These services require pre-certification from *UMR* if charges exceed $250.

Home Health Care: *Home health care* is an outpatient service that is rendered to a patient in a home setting in lieu of *hospital confinement.* Benefits are provided for *home health care* when services are rendered by a licensed and/or accredited *home health care* agency. While *custodial care* may be rendered in the home and therefore is a form of *home health care,* it is excluded under the *Plan.*

Home health care services may include the skills and services of a nurse (RN or LPN), physical therapist, occupational therapist, speech therapist, and medical *social worker.*

These outpatient *medical services* are covered to the extent that such charges would have been considered *covered charges* had a person required *confinement* in the *hospital* as a registered bed patient, or *confinement* in a *skilled nursing facility.*

Home health care requires pre-certification from *UMR* to determine *medical necessity.* A determination of *medical necessity* is based upon, but is not limited to, the level of skill required, the number of hours required, whether or not the treatment plan is appropriate (and whether or not it includes any related patient/family training goals), and the review of possible *custodial care*. Ongoing authorization is required and is based upon regular updates from the *home health care* agency or *provider.*

The nursing care may be provided by a registered nurse (RN) or licensed practical nurse (LPN) who does not ordinarily live in your home and who is not a member of your immediate family. The services provided by a nurse are divided into two categories: nursing visits and nursing care.

Nursing visits are defined as services rendered by an RN or LPN in the home care setting as ordered by a *physician.* These services are rendered on an intermittent basis for initial and ongoing assessment, treatment, and/or training. A nursing visit includes tasks and skills that a caregiver may be able to perform after appropriate training. One visit is equal to 2 hours or less within the same 24-hour period. These benefits are limited as listed in **Plan Limitations and Provisions**.

Nursing care is defined as services rendered by an RN or LPN in the home care setting as ordered by a *physician.* The services are rendered on an hourly or per diem basis for patients who require ongoing assessment, treatment, evaluation, and training. Nursing care includes tasks and skills that a caregiver may be able to perform after appropriate training. Nursing care for the purpose of training one or more caregivers is covered under this *Plan* provision. Trainable services are identified as part of the initial assessment by the home health nurse and are to be included in the treatment plan. If the nursing care agency indicates that the caregiver has refused to participate or has elected not to provide the services to the patient in those areas identified as trainable, then this refusal is considered to be a matter of convenience for the caregiver. In this case, trainable nursing services would be excluded under the *Plan.* Only those services for which a caregiver cannot be trained and that are *medically necessary* are covered under this provision. Nursing care includes hourly care that extends beyond two hours per day. These benefits are limited as listed in **Plan Limitations and Provisions**.

Medical social services are also covered, and are defined as the practice involving the disciplined application of social work values, principles, and methods. These services are provided to a patient in a home environment if a patient and/or *family* is having difficulty adjusting to physical, psychological, financial, environmental, or familial limitations that inhibit recovery from an *illness* or *injury.* A Masters-prepared *social worker* (MSW) may provide advice and counsel, and instruct in the utilization of appropriate community resources. Social work services rendered in the home require pre-certification from *UMR* and are subject to the overall home health visit limit as defined in **Plan Limitations and Provisions**.

***Hospice* Care:** *Hospice* care benefits for a terminally ill *Plan participant* are provided according to the **Schedule of Benefits**. These services require pre-certification from *UMR*. The *medical services* and supplies of this benefit are to be provided under the terms of an approved *hospice* care plan and can include:

- Room and board for *confinement* in a *hospice*.
- Services and supplies furnished by the *hospice* while the patient is confined.
- Part-time nursing care by or under the supervision of a registered nurse.
- Nutrition services and/or special meals.
- *Respite services*.
- Counseling services by a licensed *social worker* or a licensed counselor.
- Bereavement counseling by a licensed *social worker* or a licensed counselor for covered survivors only. These benefits are limited as listed in **Plan Limitations and Provisions**.

Prescription Drugs

This *Plan* provides benefits for prescription drugs ordered in writing by a *physician* for treatment *incurred* because of an *accidental injury* or *illness,* or as a result of pregnancy, childbirth, or a related medical condition.

Prescription Drug Card Program

When you purchase your prescription drugs through the retail drug card program and use a *participating pharmacy* (a pharmacy that honors your prescription drug card), simply present your prescription drug card and make the required co-payment as indicated in the **Schedule of Benefits**.

Each prescription has a 30-day supply limit, unless otherwise limited by state or federal law. After two 30-day retail fills of a prescription drug, the mail service becomes mandatory for that prescription.

Co-payments or coinsurance payments for the prescription drug card program do not apply to the out-of-pocket maximum.

Prescription Drug Benefits — Mail Order

Benefits are also provided to *Plan participants* for maintenance prescription drugs through a mail order program as indicated in the **Schedule of Benefits**.

Each prescription has a 90-day supply limit, unless otherwise limited by state or federal law. The mail service is mandatory for prescription drugs needed for 90 or more consecutive days (after two 30-day retail fills of a prescription).

Co-payments or coinsurance payments for mail order prescription drugs do not apply to the out-of-pocket maximum.

How to Use the Mail Order Service

To participate in the mail service*:*

- Obtain a copy of the mail order form from the Human Resources Department.
- Complete the patient profile questionnaire (for your first order only).
- Ask your *physician* to prescribe the needed medication for a 90-day supply, plus refills.
  - ♦ If you are presently taking medication, you will need a new prescription.
  - ♦ If you need the medication immediately, **but will be taking it on an ongoing basis,** ask your *physician* for two prescriptions: one for a smaller supply that you can have filled at a local pharmacy, and one for the balance of the prescription, up to a 90-day supply, that you can submit through the mail service provisions.
- Send the completed patient profile questionnaire to the address on the form along with your original prescription(s).

Once your order is processed, it will be sent to you via First Class Mail and will include instructions for the re-order of future prescriptions and/or refills.

Covered Prescriptions

Under the prescription drug program, covered benefits include:

- federal legend drugs.
- state-restricted drugs.
- insulin.
- syringes and needles used only to inject insulin.
- others as outlined in the prescription plan documents.

Exclusions and Limitations — Prescription Drugs

The following services and supplies are not covered:

∅ ***Experimental* or *investigational* drugs,** including medication or compounded medications for non-FDA-approved use.

∅ **Fertility medications.**

∅ **Hair growth medications.**

∅ **Non-legend drugs,** other than insulin.

∅ **Over-the-counter medications.**

∅ ***Physician's* office:** drugs intended for use in a *physician's* office or in another setting other than the home. These drugs may be covered under the medical provisions of the *Plan.*

∅ **Prescription medications filled 60 days** or more after the prescription was written.

∅ **Therapeutic devices** or appliances, support garments, and other non-medical substances.

∅ **Workers' Compensation:** prescriptions that an eligible person is entitled to receive, without charge, under any Workers' Compensation law, or under any municipal, state, or federal program.

Replacement of Organs/Tissues and Related Services

You must complete the Pre-Certification of Inpatient Services Program prior to hospitalization for an organ *transplant*, bone marrow *transplant*, or tissue replacement to establish the *medical necessity* of the procedure. See the definition of *"transplant"* in the **PLAN DEFINITIONS** section. **Services must be received at a Center of Excellence or they will not be covered.** A Center of Excellence is a facility which has entered into an agreement through a national organ *transplant* network to render approved *transplant* services, to which Lexington Precision Corporation has access. The Center of Excellence facility will be determined by Lexington Precision Corporation and may or may not be located near the geographic area where you reside.

Inpatient services for *transplantation* are covered according to the **SCHEDULE OF BENEFITS** and the lifetime maximum of the *Plan*. Services and supplies rendered in connection with the procedure that are considered to be *investigational* or *experimental* are not covered. See the definitions of *"investigational"* and *"experimental"* in the **PLAN DEFINITIONS** section.

Solid Organs

This *Plan* provides benefits for the *transplantation* of solid human organs (with other human organs) and related services. This *Plan* excludes *transplantation* of non-human organs.

Bone Marrow Transplants

This *Plan* provides benefits for *medically necessary* bone marrow *transplantation* procedures, including, but not limited to, synergic and allogenic/homologous bone marrow *transplantation*, as well as autologous bone marrow *transplantation* procedures.

Finding a donor who is an acceptable match for donation is important to the success of an allogenic/homologous bone marrow *transplant*. Because an immediate family member has the greatest chance of being a match, benefits for determining bone marrow matching are provided only for members of the immediate family and only if the proposed bone marrow *transplantation* is *medically necessary* and is not considered *experimental* or *investigational.* For purposes of this section, immediate family members include mother, father, biological children, and biological siblings. If a donor match cannot be identified in the immediate family, the *Plan* will cover matching through a national registry.

Tissue Replacement

This *Plan* also provides benefits for the replacement of human tissue (with human tissue or prosthetic devices).

Other Benefits Related to Transplantation

Benefits are also provided for:

- the preparation, acquisition, transportation, and storage of human organs, bone marrow, or human tissue.
- transportation of the *Plan participant*, if the organ recipient, to and from the site of the *transplant* procedure.

Specific rules apply as to the payment of benefits for the donor and recipient of the *transplanted* organ, bone marrow, or tissue.

- When the *transplant* recipient and donor are **both** covered under this *Plan*, payment for covered services is provided for both, subject to each *Plan participant's* respective benefit maximums.
- When the *transplant* recipient is covered under this *Plan* but the donor is not, payment for covered services is provided for both the recipient and the donor to the extent that charges for such services are

not payable by any other source. Benefits payable on behalf of the donor are charged to the recipient's claim and applied to the recipient's maximums.

- When the *transplant* recipient is not covered under this *Plan* but the donor is covered, payment for covered services attributable to the donor is provided to the extent that charges for such services are not payable by any other source. Benefits are not provided for services attributable to the recipient.

Other Covered Medical Expenses

The *Plan* covers charges that are reasonable for many services and supplies. The following are covered:

- ***Accidental injury* to sound *natural teeth*.**
  - A sound *natural tooth* is defined as one that is a virgin, or unrestored, tooth, or as one that, if it has a pre-existing restoration, has two or fewer surfaces restored and the restoration does not encompass more than 1/3 of the width of the occlusal surface or involve a cusp.
  - An *injury* caused by chewing or biting is not considered an *accidental injury*.
- **Blood transfusions and blood products** to the extent the blood bank supply is not replaced.
- **Botox,** if *medically necessary*.
- **Cochlear implants,** if *medically necessary*.
- ***Cosmetic services*** in connection with a congenital malformation or *accidental injury,* if *medically necessary.*
- **Eating disorders,** if *medically necessary*.
- **Enteral nutrition and non-oral food supplements** under the following conditions:
  - For a patient with permanent non-function of the small bowel or of the structures that normally permit food to reach the small bowel.
  - For a patient with disease of the small bowel that impairs digestion and absorption of an oral diet to the point that the patient would become critically ill without the enteral feeds.
  - In which it is life-sustaining for a critically ill patient.
- **Home and office calls** by *physicians* for diagnosis and treatment.
- **Impacted teeth:** extraction of impacted teeth.
- **Mastectomy:** mastectomy and all stages of reconstruction of a breast on which a mastectomy has been performed due to cancer or tumor fibrocysts, including the cost of prostheses and physical complications of all stages of mastectomy, including lymphedemas, as such services are recommended by the attending *physician* in consultation with the patient.
  - If you have received a mastectomy **at any time,** and you are continuing to receive any benefits under this *Plan* directly related to that mastectomy on or after **January 1, 1999**, this provision includes coverage for any reconstructive surgery on the opposite breast necessary to produce a symmetrical appearance.
- **Nicotine transdermal patches:** one per lifetime.
- **Norplant.**
- **Oral supplements or augmentation** for treatment of the following inborn errors of metabolism: phenylketonuria (PKU), maple syrup urine disease (MSUD), homocystinuria, histidinemia, and

tyrosinemia. This includes special medical foods or oral formulas specifically designed to restrict the intake of amino acids. This does not include any over-the-counter supplements or formulas that may be used in conjunction with the prescribed treatment.

- **Orthotics and supportive devices,** rigid or semi-rigid, that limit or stop motion of a weak or diseased body part.
  - These services require pre-certification from *UMR* if charges exceed $250.
- **Oxygen**, only for medical purposes, and an oxygen concentrator, when deemed by the *Plan* to be *medically necessary*.
- **Prosthetic devices and supplies:** purchase, fitting, needed adjustment, repairs, and replacements of prosthetic devices and supplies that replace all or part of a missing body extremity (except teeth) and its adjoining tissues, or that replace all or part of the function of a permanently useless or malfunctioning body organ or extremity. Benefits are limited to one prosthetic device per lifetime and are provided to adults only.
  - These services require pre-certification from *UMR* if charges exceed $250.
  - The *Plan* covers charges for contact lenses following cataract surgery.
  - The *Plan* covers charges for orthopedic inserts and their fitting as prescribed by a *physician* as being *medically necessary.*
- **Self-inflicted *illness* or *injury.***
- **Smoking cessation programs:** one per lifetime.
- **Sterilization procedures, elective** (adult male and female) for the *employee* and covered *spouse* only.
- **Surgical dressings, splints, casts**, and other devices used in the reduction of fractures and dislocations, as well as other similar items that serve only a medical purpose, excluding items usually stocked in the home.
- **Syringes, needles,** and other similar items that serve only a medical purpose, excluding items usually stocked in the home.

Care Outside the United States

Benefits equivalent to those in *hospital*s in the United States are provided to *Plan participants* in the event of an *emergency* while traveling or vacationing outside the United States. If you receive such services, pay the *provider* and then submit the bill to *UMR* for reimbursement. Only *medically necessary* treatment as in the case of *emergency illnesses* and *accidental injuries* is covered when services are rendered by a *provider* outside the United States. Routine or preventative care is not covered. Any hospitalization requires the Pre-Certification steps to be completed.

Employees (and their *covered dependents*) residing outside the United States as a condition of an *employee's* employment by the *Company*, and *covered dependents* outside the United States who are approved in advance by the *Plan Administrator,* are eligible for benefits for medical coverage and *hospital* services equivalent to those provided to *Plan participants* within the United States. When obtaining services outside the United States, the *Plan participant* is encouraged to obtain a pre-determination of benefits before receiving services from the *provider.* Benefits are provided only for services rendered by facilities that meet the standards of their localities comparable to those established by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or for services rendered by *physicians* meeting the credentials of their localities comparable to the credential of Board

Certification from the American Medical Association (AMA). Benefits are not provided for any services considered *experimental* or *investigational*.

Exclusions and Limitations — Medical

The following services and supplies are NOT covered by this *Plan*:

- ∅ **Abortion, elective,** unless the mother's life is endangered.
- ∅ **Absence of coverage:** charges that would not have been made in the absence of coverage.
  - ◊ This includes charges that are submitted to the *Plan* equal to any amount that the *provider* has discounted his or her fees or has "written off" amounts due.
- ∅ ***Accidental injury:*** *injuries* resulting from an accident for which you are reimbursed or entitled to be reimbursed by another party or insurer; however, the *Plan* may make payment on these claims with the understanding that the *Plan* will be reimbursed in accordance with the subrogation provision contained in the SUBROGATION section of this Summary Plan Description.
- ∅ **Acupressure.**
- ∅ **Acupuncture.**
- ∅ **Artificial insemination.**
- ∅ **Birth control drugs or devices**, whether or not dispensed by prescription, that are purchased or prescribed for the sole purpose of preventing conception, unless covered by the provisions of your prescription drug card plan.
  - ◊ This exclusion does not apply to devices dispensed in a doctor's office.
- ∅ **Breast surgery or services:** altering the size or shape of the breast, male or female, whether elective or not.
  - ◊ This exclusion does not apply to reconstructive surgery performed as a result of a mastectomy due to cancer or tumor fibrocysts, either on the affected breast or, for mastectomy benefits received on or after **January 1, 1999**, on the opposite breast for the purpose of achieving a symmetrical appearance.
  - ◊ This exclusion does not apply to breast reduction surgery if a treatment plan is submitted in advance to *UMR* and the *Plan participant* has multiple medical conditions that are worsened by the natural size of the breasts.
- ∅ **Charges in excess of the *semi-private room* rate**, except as otherwise noted.
- ∅ **Chiropractic *maintenance care*.**
- ∅ **Civil insurrection or riot:** treatment or services for *injuries incurred* or exacerbated while participating in a civil insurrection or riot.
- ∅ **Claims** received by *UMR* later than one year from the date of service.
- ∅ **Completion of claim forms.**
- ∅ **Corrective shoes.**
- ∅ ***Cosmetic services* or aesthetic services** (including complications).
  - ◊ This exclusion does not apply to an *accidental injury* or *illness*, if *medically necessary.*
  - ◊ This exclusion does not apply to correct a congenital anomaly, if *medically necessary.*
  - ◊ This exclusion does not apply to Botox, if *medically necessary*.

- ∅ **Court-ordered services,** unless documented to be *medically necessary.*
- ∅ ***Custodial care,*** except as specified.
- ∅ **Dental *hospital* admissions,** except for the *medical necessity* of a concomitant condition.
- ∅ **Dental prescriptions** (e.g., Peridex, fluoride). These items may be covered under your prescription drug card program.
- ∅ **Dental services,** except for the extraction of impacted teeth.
- ∅ **Diagnostic studies:** room and board or general nursing care for *hospital* admissions solely for diagnostic studies.
- ∅ **Dietary supplements:** products taken by mouth that contain a "dietary ingredient" intended to supplement the diet. These are typically over-the-counter products used in conjunction with a regular diet.
- ∅ **DNA testing.**
- ∅ **Drugs and medicines** that, as required by law, may be dispensed only by a registered pharmacist on the written prescription of a *physician* (excluded by the medical provisions of the *Plan*). Prescription drugs may be covered under your prescription drug card plan and prescription drug mail service program.
  - ◊ This exclusion does not apply to drugs and medicines dispensed by a registered pharmacist on the written prescription of a *physician* while the *Plan participant* is an inpatient in a *hospital*.
- ∅ **Educational, vocational, or training purposes,** services or supplies.
  - ◊ This exclusion does not apply to educational services rendered for diabetic counseling, peritoneal dialysis, or any other educational service deemed to be *medically necessary* by the *Plan.*
- ∅ **Environmental change,** hospitalization (such as hospitalization for children or adolescents due to family adjustment or relationship disorders).
- ∅ ***Experimental* or *investigational* treatment:** expenses for any *experimental* or *investigational* treatment, or for any *hospital confinement* or treatment that results from *experimental* or *investigational* treatment.
- ∅ **Eyeglasses, contact lenses, refractions**, or the examination for their prescription and fitting.
  - ◊ This exclusion does not apply to Aphakic patients.
  - ◊ This exclusion does not apply to soft lenses or sclera shells intended for use as corneal bandages.
  - ◊ This exclusion does not apply to contact lenses following cataract surgery.
- ∅ **Felonious act:** *covered charges* for any period caused or contributed to by a *Plan participant* committing or attempting to commit an assault, felony, or illegal act, participating in an illegal occupation, or actively participating in a violent disorder or riot. Also excluded under this item are *covered charges* for any period a *Plan participant* is confined for any reason in a jail, prison, correctional institution, or in the *Plan participant's* home.
- ∅ **Fertility drugs.**
- ∅ **Foot care services, routine**, including, but not limited to, cutting or removal of corns or calluses, the trimming of nails, and other hygienic and preventative and maintenance care, performed in the absence of localized *illness, injury*, or symptoms involving the foot.
- ∅ **Gamete intrafallopian transfer (GIFT).**
- ∅ **Gastric bypass.**

- ∅ **Genetic testing, gene therapies, xenographs for cloning, and/or counseling.**
- ∅ **Government services:** services furnished by a government or division thereof, except a program for civilian employees of a government.
- ∅ **Growth hormone therapy.**
- ∅ ***Halfway house*.**
- ∅ **Hearing aids or devices.**
- ∅ **Hypnotherapy.**
- ∅ **Immediate family:** treatment provided by a member of your immediate family.
- ∅ **Impotence treatment and medications.** These items may be covered under your prescription drug card program.
- ∅ **In vitro fertilization.**
- ∅ ***Infertility* treatment.**
- ∅ **Learning *disabilities*.**
- ∅ ***Maintenance care*.**
- ∅ **Marital counseling.**
- ∅ **Massage therapy,** unless applied in conjunction with other active physical therapy modalities for a specific *illness* or *injury.*
- ∅ **Medically unnecessary services:** services that are not *medically necessary* to the care and treatment of any *injury* or *illness,* except where otherwise specified.
- ∅ **Mental illness:** any mental illness condition listed in Appendix G of the DSM-IV, titled "ICD-9-CM codes for Selected General Medical Conditions and Medication Induced Disorders," or any comparable listing if Appendix G is no longer published.
- ∅ ***Military service:*** treatment or services resulting from or prolonged as a result of performing a duty as a member of the *military service* of any state or country.
- ∅ **Missed appointments.**
- ∅ **Music therapy.**
- ∅ **Nicorette gum.**
- ∅ **Not eligible:** charges *incurred* while not eligible for a benefit, such as prior to your effective date or subsequent to your coverage termination date.
- ∅ **Obesity treatment**, including any care that is primarily dieting or exercise for weight loss.
  - ◊ This exclusion does not apply to benefits for non-surgical treatment of morbid obesity if a treatment plan has been submitted to and approved by the *Plan* prior to initiation of treatment.
- ∅ **Orthognathic surgery** (jaw realignment surgery) to correct retrognathia, apertognathia, prognathism, open bite malocclusion, or transverse skeletal deformities.
- ∅ **Patient convenience:** expenses *incurred* in the modification of homes, vehicles, or personal property to accommodate patient convenience items. This includes, but is not limited to, the installation of ramps, elevators, air conditioners, air purifiers, TDD/TTY communication devices, personal safety alert systems, exercise equipment, and cervical pillows.

- ∅ **Penalties** for non-compliance with the Pre-Certification of Inpatient Services Program or non-compliance with the Pre-Certification of Outpatient Services Program.
- ∅ **Penile implants,** unless needed due to an organic condition.
- ∅ **Personal hygiene** or convenience items.
- ∅ **Physical therapy admissions:** room and board or general nursing care for *hospital* admissions solely for physical therapy.
- ∅ ***Pre-existing conditions***, except as noted elsewhere.
- ∅ **Premarital tests** not incidental to the treatment of a manifested *injury* or *illness.*
- ∅ **Prenatal vitamins.** These items may be covered under your prescription drug card program.
- ∅ **Preoperative and postoperative visits** made by your surgeon or assistant surgeon on or after the date of your surgery, if billed as a separate line item.
  - ◊ This exclusion shall not apply to preoperative or postoperative visits that are appropriate to bill separately based on medical and procedural coding criteria.
- ∅ **Prohibited by law:** charges for which the *Plan* is prohibited by law or regulation from providing benefits.
- ∅ **Radial keratotomy, keratomileusis, or other vision correction procedures.**
- ∅ **Reimbursement:** *injuries* resulting from an accident for which you are reimbursed or entitled to be reimbursed by another party or insurer; however, the *Plan* may make payment on these claims with the understanding that the *Plan* will be reimbursed in accordance with the subrogation provision contained in the SUBROGATION section of this Summary Plan Description.
- ∅ **Remedial reading therapy.**
- ∅ ***Residential care facility.***
- ∅ **Reversal of sterilization**, male or female.
- ∅ **Sclerotherapy** for varicose veins, unless *medically necessary.*
- ∅ **Sex change or implantation.**
- ∅ **Sexual dysfunctions.**
- ∅ **Stop loss:** any exclusion that may from time to time be set forth in any stop loss insurance policy that may be in place to reimburse the *employer* for claims paid under the *Plan* in excess of amounts specified in the stop loss policy.
- ∅ **Surrogate parent agreement**, whether written or oral.
- ∅ **Tax and shipping** levied on *medically necessary* items and services.
- ∅ **Teeth or gum treatment,** or the fitting or wearing of dentures.
  - ◊ This exclusion shall not apply to treatment of *accidental injury* to sound *natural teeth*.
- ∅ **Telephone and television** service while confined as an inpatient.
- ∅ **Telephone consultations.**
- ∅ ***Transplants:*** expenses for any *transplant* not included in the definition of *"transplant."*
- ∅ **Travel**, even though prescribed by a *physician*.

- ◊ This exclusion may not apply to a *Plan participant* who is an organ *transplant* recipient to travel to and from the site of the *transplant*.

- ∅ ***UCR*, over:** the portion of any charge that is in excess of the *UCR* charge for the particular service or supply.
- ∅ **Vitamins,** except in cases of deficiency. These items may be covered under your prescription drug card program.
- ∅ **War:** charges for services or supplies that arise out of or are caused or contributed to by war or any act of war, whether declared or undeclared, whether civil or international; or due to any substantial armed conflict between organized forces of a military nature; or services or supplies *incurred* in connection with full-time active *military service* in the armed forces of any country or international authority.
- ∅ **Weekend *hospital* admissions, elective,** unless care is rendered within 24 hours.
- ∅ **Without approval:** services furnished without recommendation and approval of a *physician* acting within the scope of his or her license.
- ∅ **Work-related *illness* or *injury*:** treatment for an *illness* or *injury* arising out of, or in the course of, any employment for wage or profit, including, but not limited to, employment with Lexington Precision Corporation, without regard to whether such *illness* or *injury* entitles the *employee* or *covered dependent* to Workers' Compensation or similar benefits.
- ∅ **Zygote intrafallopian transfer (ZIFT).**

HEALTH MANAGEMENT SERVICES AND SPECIAL PROVISIONS

It is important to remember that this *Plan* covers only those procedures, services, and supplies that are *medically necessary* unless otherwise specified.

Services that are NOT considered to be *medically necessary* include, but are not limited to:

- Procedures of unproven value or of questionable current usefulness.
- Procedures that could be unnecessary when performed in combination with other procedures.
- Diagnostic procedures that are unlikely to provide a *physician* with additional information when used repeatedly.
- Procedures that are not ordered by a *physician* or that are not documented in a timely fashion in the patient's medical record, or that can be performed with equal effectiveness at a lower level of care facility (e.g., on an outpatient basis).

For example, a medically unnecessary *hospital* admission would be one that does not require acute *hospital* bed patient care and could have been provided in a *physician's* office, *hospital* outpatient department, or lower level of care facility without reduction in the quality of care provided and without harm to the patient. Also, a *hospital* admission primarily for observation, evaluation, or diagnostic study that could be provided adequately and safely on an outpatient basis is considered to be medically unnecessary.

Case Management

Case management is a service that your *employer* has included in your benefit *Plan* at no cost to you. *UMR* case managers are registered nurses with extensive clinical experience.

When you are suffering from a serious *injury* or *illness* and/or require extensive treatment, you may be offered case management. You or your family may request this service at any time.

When this service is requested, a case manager will contact you by phone and/or by mail to request your consent. Should you decide to give consent for case management, the case manager can:

- Help you make the best use of your health care benefits.
- Be an advocate in regards to benefits and helping you obtain needed services within the confines of your benefit *Plan*.
- Provide you with information about your particular *illness(es)* and/or treatment options.
- Help you access needed resources, medications, and/or medical equipment.
- Answer your questions about the plan of treatment, help you prepare for medical appointments, and help you get information about your medical claims.

You may request a case manager at any time by calling *UMR* at the toll-free number on your ID card and asking the operator to connect you with your claims team representative.

Case managers will maintain your confidentiality according to federal guidelines. Once assigned a case manager, you may call anytime at the toll-free number your case manager provides.

Pre-Certification of Inpatient Services

A *hospital* stay can be a serious and expensive part of your course of treatment. This *Plan* has a special program, Pre-Certification of Inpatient Services, to make sure that you are not hospitalized unnecessarily.

If you are admitted to (or registered as a patient at) a *hospital* or a *rehabilitation facility*, whether for *emergency* treatment, elective non-emergency treatment, or maternity care in excess of 48 hours for normal delivery or 96 hours for cesarean delivery, you or a member of your family should call *UMR*. The completion of this program is the sole responsibility of the *Plan participant.*

Urgent Care or Emergency Admissions

It is important to remember that, if a *Plan participant* needs medical care for a condition that could seriously jeopardize his or her life, there is no need to contact the *Plan* for prior approval. The *Plan participant* should obtain such care without delay.

If you or a *covered dependent* must be admitted on an *emergency* basis, follow the *physician's* instructions carefully and contact *UMR* by telephone within two business days after the admission date.

The contact may be made by you, a family member, or your *provider*. The *Plan* does not require you or a *covered dependent* to obtain approval of a health care service prior to getting treatment for an urgent care or *emergency* situation, so there are no "pre-service urgent care claims" under the *Plan*. In an urgent care or *emergency* situation, simply follow the *Plan's* procedures with respect to any notice that may be required after receipt of treatment, and file the claim as a post-service claim.

Non-Emergency Admissions

For inpatient services that are scheduled in advance, call *UMR* as soon as possible before actual services are rendered.

UMR's nurse and your admitting *hospital* review your inpatient treatment plan before and during your hospitalization. The objective is to help you obtain all the information you need to make informed decisions. The *UMR* nurse:

- checks *medical necessity* of the *hospital* admission and length of stay against generally accepted medical standards, and
- suggests alternative treatment settings, if appropriate.

You will be notified by mail of the approved length of stay. Additional days may be assigned based on *medical necessity*.

Pre-Certification Penalty

The program requires the support and cooperation of each *Plan participant*. The final decision regarding treatment and hospitalization is yours. Maximum allowable *Plan* benefits are paid as long as a *Plan participant* follows the above instructions and procedures for any inpatient hospitalization. However, if a *Plan participant* fails to notify *UMR* of any inpatient hospitalization as required above, allowed charges will be reduced as follows and the *Plan participant* will be responsible for payment of the part of the charge that is not paid by the *Plan*.

If you fail to follow these steps, the *Plan* pays your claim at a reduced amount. After the benefits payable under this *Plan* are calculated, the benefits are further reduced by $500. The reduction of the claim, for which you are responsible, cannot be used to satisfy the annual deductible or the annual out-of-pocket maximum.

Pre-Determination of Medical/Surgical Benefits

The Pre-Determination of Medical/Surgical Benefits Program allows you to make an informed decision before committing to a specific treatment. Participation in this program provides assurance in advance that the recommended service is *medically necessary,* is an allowable expense under the *Plan*, and is a *UCR* charge.

When your *physician* recommends that you undergo a specific course of treatment, contact *UMR* for Pre-Determination of Medical/Surgical Benefits. *UMR*:

- reviews the proposed treatment for *medical necessity,*
- checks the treatment's eligibility for coverage and the extent of coverage relative to your *Plan,* and
- reviews the proposed charges and the reasonableness of planned treatment and fees.

Upon review of the information, *UMR* returns to you and to your *physician* a determination outlining the *medical necessity* of the proposed treatment, the proposed treatment's eligibility as a *covered charge,* and whether the surgeon's fees are within the *usual, customary, and reasonable (UCR) charges* for that procedure. The decision regarding treatment remains with you and your *physician.*

Pre-determination of benefits does not guarantee payment. Exact benefits are determined based on the eligibility of the *Plan participant* at the time services are rendered.

This *Plan* does not provide benefits for certain services unless a pre-determination of benefits is obtained in advance. Refer to the **Exclusions and Limitations — Medical** section.

It is important to remember that, if a *Plan participant* needs medical care for a condition that could seriously jeopardize his or her life, there is no need to contact the *Plan* or *UMR* for pre-determination of benefits. The *Plan participant* should obtain such care without delay.

Pre-Certification of Outpatient Services

With the exception of urgent care or *emergency* services as explained below, the Pre-Certification of Outpatient Services Program allows you to verify, in advance of receiving a service, that the recommended service is *medically necessary,* is an allowable expense of the *Plan*, and is within reasonable costs. If your *physician* recommends any of the outpatient procedures on the following list, contact *UMR* as instructed below:

- Arthroscopy.
- Cardiac catheterization performed more than one time during any 12-month period.
- Cardiac rehabilitation programs.
- Chemotherapy.
- Cochlear implants.
- *Durable medical equipment* at or greater than $250. This includes prosthetic, orthotic, or orthopedic appliances.
- *Home health care* services.
- *Hospice* care services.
- Laser-assisted uvulopalatoplasty (LAUP).
- Magnetic resonance imaging (MRI).
- Occupational therapy.
- Outpatient surgeries performed in outpatient facilities.
- Pain management programs.
- Physical therapy.

- Sclerotherapy.
- Sleep studies.
- Speech therapy.

Urgent Care or Emergency Outpatient Services

It is important to remember that, if a *Plan participant* needs medical care for a condition that could seriously jeopardize his or her life, there is no need to contact the *Plan* for prior approval. The *Plan participant* should obtain such care without delay.

If you or a *covered dependent* must obtain outpatient medical treatment or services on an *emergency* basis, follow the *physician's* instructions carefully and contact *UMR* by telephone within two business days after the date on which the medical treatment or services were provided.

The contact may be made by you, a family member, or your *provider*. The *Plan* does not require you or a *covered dependent* to obtain approval of a health care service prior to getting treatment for an urgent care or *emergency* situation, so there are no "pre-service urgent care claims" under the *Plan*. In an urgent care or *emergency* situation, simply follow the *Plan's* procedures with respect to any notice that may be required after receipt of treatment, and file the claim as a post-service claim.

Non-Emergency Outpatient Services

For outpatient services that are scheduled in advance, call *UMR* as soon as possible before actual services are rendered.

Pre-Certification Penalty

The program requires the support and cooperation of each *Plan participant*. The final decision regarding treatment is yours. Maximum allowable *Plan* benefits are paid as long as a *Plan participant* follows the above instructions and procedures for any outpatient medical treatment or services. However, if a *Plan participant* fails to notify *UMR* of any outpatient medical treatment or services as required above, allowed charges will be reduced as follows and the *Plan participant* will be responsible for payment of the part of the charge that is not paid by the *Plan*.

If you fail to follow these steps, the *Plan* pays your claim at a reduced amount. The applicable *covered charges* are reduced by 20%, and then the benefits payable under this *Plan* are calculated, to a maximum penalty of $500 per occurrence. The reduction of the claim, for which you are responsible, cannot be used to satisfy the annual deductible or the annual out-of-pocket maximum.

Prenatal Care Program — Baby & Me

The prenatal care program sponsored by the *Plan* provides you with support services and maternity information during your pregnancy. The program is designed to help you make informed choices that will give your baby the best chance of being born strong and healthy. The program includes a health assessment survey, a postpartum survey, and phone access to an experienced maternity nurse case manager who can answer questions or address concerns you may have during pregnancy. As a participant in the Baby & Me program, you will receive health education materials related to your specific needs as identified in the health assessment survey.

You must enroll in the Baby & Me program within your first trimester of pregnancy, or benefits will be paid at the out-of-network rate even if services are received in-network

When you learn that you or your *covered dependent* is pregnant, you may enroll by calling 1-800-837-7927, or by visiting the *UMR* website at http://www.umr.com, clicking on "Members," and taking the

Baby & Me survey. Enrollment by either of these methods is available 24 hours a day, 7 days a week. This contact should be made before the end of the first trimester.

HOW TO FILE A CLAIM

UMR, the *claims administrator*, is responsible for keeping the records of each *Plan participant's* benefits and for processing claims filed with the *Plan.* **Each *Plan participant* is responsible** for making sure that claims are submitted on a timely basis. Ordinarily, this will not require the submission of a claim form since most *physicians* and *hospitals* submit bills for service directly to *UMR.*

In some cases you may be required to submit a bill and claim form directly to *UMR*. See the SUBMISSION OF CLAIMS section for detailed instructions on claim submission. In either case, you must make sure that all bills are submitted according to the TIMELY FILING PROVISION section of this document.

Timely Filing Provision

You or your *provider* may submit claim requests any time during the calendar year, January 1 through December 31. **All claims *incurred* during a calendar year must be received by *UMR* no later than one year from the date you received the services. Claims filed later than that date shall be denied.**

Benefits are based upon the *Plan's* provisions at the time the charges were *incurred*.

A pre-service non-urgent claim (including a concurrent claim that also is a pre-service non-urgent claim) is considered to be filed when the request for approval of treatment or services is made and received by the *claims administrator* in accordance with the *Plan's* procedures.

A post-service claim is considered to be filed when the following information is received by the *claims administrator*, together with a Form HCFA or Form UB92:

- The date of service;
- The name, address, telephone number, and tax identification number of the *provider* of the services or supplies;
- The place where the services were rendered;
- The diagnosis and procedure codes;
- The amount of charges (including re-pricing information);
- The name of the *Plan*;
- The name of the covered *employee*; and
- The name of the patient.

Upon receipt of this information, the claim will be deemed to be filed with the *Plan*.

The *claims administrator* will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested as provided herein. This additional information must be received by the *claims administrator* within 45 days from receipt by the *Plan participant* of the request for additional information. **Failure to provide the information by this deadline may result in claims being declined or reduced.**

Hospital Claims

Most *hospitals* will submit your claim directly to *UMR*. You need only present your identification card to the *hospital* admitting office when you or a *covered dependent* is admitted as a *hospital* inpatient or receives treatment as a *hospital* outpatient.

When you are discharged or a few days after discharge, you should receive an itemized bill from the billing office. If the bill does not indicate that it has been submitted to *UMR*, contact the billing office for clarification of the *hospital's* billing procedures.

Physician Claims

In most cases, when you or a *covered dependent* receives treatment at a *physician's* office, the office submits the claim directly to *UMR* on your behalf. If it does not, you must submit the claim directly. In those instances, see the **Submission of Claims** section.

Other Expenses

Each time you *incur* expenses for *covered charges*, you must keep a receipt that can be submitted with your claim form. You must keep separate records for each *Plan participant*. To make a claim, complete a claim form, attach the appropriate receipts, and send the information to *UMR*. Be sure to include:

- Patient's full name.
- Nature of treatment or service rendered.
- License number of professional, e.g., registered nurse.

Prescription Drug Expenses

When you purchase prescription drugs at a *participating pharmacy* (a pharmacy that honors your prescription drug card), simply present your card and make the required co-payment or pay the required coinsurance.

Should you require a prescription drug and a *participating pharmacy* is not available (for example, when you are on vacation), you may have your prescription filled at a *non-participating pharmacy*. However, you must pay that pharmacy the total amount of the charges. You may make a claim for those charges by obtaining the necessary form from the Human Resources Department. You must complete the form, attach the receipts, and forward it to the address listed on the form.

Submission of Claims

If you find that you must submit a claim directly to *UMR*, follow these guidelines so that your claim can be processed as easily and quickly as possible:

- Contact the Human Resources Department to obtain the required forms for submitting a claim.
- A separate claim form should be submitted for each *Plan participant*.
- You are responsible for completing the *employee* section of the claim form and for submitting the form to *UMR*.
- Request that the *provider* complete the remaining portions. (Frequently the *provider's* receipt contains the pertinent information.)
- The form must be signed by the *employee* or *covered dependent* (except in the case of a minor).
  - ♦ When you make a claim for a *covered dependent* who is a *full-time student*, *UMR* requires that you submit a copy of the student's current schedule (once per school term).
- Information must be provided for each section of the claim form or it will be returned, and processing delayed.

- Each claim should include all necessary *provider* bills. The claim cannot be processed without these documents. Forward the claim form and necessary receipts to *UMR*.
  - ♦ All bills must include:
    - ∗ Group *Plan* number: **010103LP.**
    - ∗ Patient's full name.
    - ∗ Diagnosis.
    - ∗ Type of service or supply.
    - ∗ Itemized charge.
    - ∗ Date(s) of service.
    - ∗ *Provider's* name, title, tax ID number, and address.
- Be sure to designate on the form whether payment is to be made to you directly or to your *provider*.
- Canceled checks, balance due statements, or cash register receipts are not acceptable forms of statements for services rendered and are not accepted in place of bills.
- When requested, you must furnish any required information regarding other group or third party medical benefits for which the *Plan participant* is eligible.
- The *Plan participant* is required to fully and truthfully complete the claim for benefits and supply any pertinent information from personal or professional sources, as may be required by *UMR*.
- If you need to contact *UMR*, be sure to identify yourself as a *Plan participant* of the Lexington Precision Corporation Group Medical Care Plan.

Release of Information

Part of the claim form is a release of information. You must allow *UMR* to review your medical records, as needed, if the *Plan* is to provide coverage. The *claims administrator* may, without the consent of or notice to any person, release to or obtain from any organization or person any information that the *claims administrator* deems to be necessary. This information is used only to determine your benefits. Sometimes additional information is needed before coverage can be provided. This usually relates to the coordination of benefits, subrogation, or the eligibility of certain children.

Effective Date

Payment for *covered charges* is made only when charges are *incurred* on or after the *Plan participant's* effective date of coverage, and prior to the *Plan participant's* effective date of termination of coverage.

Questions

Any time you have questions about your benefits or require assistance in making a claim, contact *UMR* at:

United Medical Resources, Inc.
P.O. Box 145804
Cincinnati, Ohio 45250-5804

513-619-3000
Cincinnati and Northern Kentucky
1-800-950-4867 Toll-Free

8:30 a.m. to 5:00 p.m. EST/EDT
Monday through Friday

When you contact *UMR*, be sure to provide the following information:

- Your name (and name of patient if not the same).
- The name of your *employer*.
- The name of your *Plan*, the Lexington Precision Corporation Group Medical Care Plan.
- Your Social Security number.
- The date(s) of service.
- The name of the service *provider*.

Claims Procedures

Plan participants must follow the procedures outlined below to obtain payment of health benefits under this *Plan*.

Claims

All claims and questions regarding health claims should be directed to the *claims administrator*. The *claims administrator* shall be ultimately and finally responsible for adjudicating such claims and for providing full and fair review of the decision on such claims in accordance with the following provisions and with ERISA. Benefits under the *Plan* will be paid only if the *claims administrator* decides, at its discretion, that the *Plan participant* is entitled to them. In carrying out its responsibilities, the *claims administrator* may request the *Plan Administrator* to provide a written clarification on the interpretation of the *Plan.* However, the final determination of both initial claims and appeals will be determined solely by the *claims administrator.*

Each *Plan participant* claiming benefits under the *Plan* shall be responsible for supplying, at such times and in such manner as the *claims administrator,* at its sole discretion, may require, written proof that the expenses were *incurred* under the *Plan*. If the *claims administrator,* at its sole discretion, shall determine that the *Plan participant* has not *incurred covered charges* under the *Plan*, or if the *Plan participant* shall fail to furnish such proof as is requested, no benefits shall be payable under the *Plan*.

Under the *Plan*, there are three types of health claims: pre-service non-urgent, concurrent care, and post-service.

Pre-Service Non-Urgent Claims

A "pre-service claim" is a claim for a benefit under the *Plan* where the *Plan* conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

A "pre-service urgent care claim" is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the *Plan participant* or the *Plan participant's* ability to regain maximum function, or, in the opinion of a *physician* with knowledge of the *Plan participant's* medical condition, would subject the *Plan participant* to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

It is important to remember that, if a *Plan participant* needs medical care for a condition that could seriously jeopardize his or her life, there is no need to contact the *Plan* for prior approval. The *Plan participant* should obtain such care without delay.

Further, because the *Plan* does not require the *Plan participant* to obtain approval of a health care service in an urgent care situation prior to getting treatment, there are no pre-service urgent care claims under this *Plan*; rather, the *Plan* requires pre-approval only for pre-service non-urgent claims. In an urgent care situation, the *Plan participant* simply follows the *Plan's* procedures with respect to any notice that may be required after receipt of treatment, and files the claim as a post-service claim.

Concurrent Claims

A "concurrent claim" arises when the *Plan* has approved an ongoing course of treatment to be provided over a period of time or number of treatments, and either (a) the *Plan* determines that the course of treatment should be reduced or terminated, or (b) the *Plan participant* requests extension of the course of treatment beyond that which the *Plan* has approved.

If the *Plan* does not require the *Plan participant* to obtain approval of a health care service prior to getting treatment, then there is no need to contact the *claims administrator* to request an extension of a course of treatment. The *Plan participant* simply follows the *Plan's* procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a post-service claim.

Post-Service Claims

A "post-service claim" is a claim for a benefit under the *Plan* after the services have been rendered.

Timing of Claim Decisions

The *claims administrator* shall notify the *Plan participant,* in accordance with the provisions set forth below, of any adverse benefit determination (and, in the case of pre-service non-urgent claims and concurrent claims, of decisions that a claim is payable in full) within the following timeframes:

Pre-Service Non-Urgent Care Claims

- If the *Plan participant* has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.
- If the *Plan participant* has not provided all of the information needed to process the claim, then the *Plan participant* will be notified as to what specific information is needed as soon as possible, but not later than 5 days after receipt of the claim. The *Plan participant* will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the *claims administrator* and the *Plan participant* (if additional information was requested during the extension period).

Concurrent Claims

- ***Plan* Notice of Reduction or Termination:** If the *claims administrator* is notifying the *Plan participant* of a reduction or termination of a course of treatment (other than by *Plan* amendment or termination), before the end of such period of time or number of treatments. The *Plan participant* will be notified sufficiently in advance of the reduction or termination to allow the *Plan participant* to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.
- **Request by *Plan Participant* Involving Non-Urgent Care:** If the *claims administrator* receives a request from the *Plan participant* to extend the course of treatment beyond the period of time or number of treatments that is a claim not involving urgent care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a pre-service non-urgent claim or as a post-service claim).

Post-Service Claims

- If the *Plan participant* has provided all of the information needed to process the claim, in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested; then prior to the end of the 15-day extension period.
- If the *Plan participant* has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the *Plan participant* will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period; then the *Plan participant* will be notified of the determination by a date agreed to by the *claims administrator* and the *Plan participant*.

Extensions – Pre-Service Non-Urgent Care Claims

This period may be extended by the *Plan* for up to 15 days, provided that the *claims administrator* both determines that such an extension is necessary due to matters beyond the control of the *Plan* and notifies the *Plan participant*, prior to the expiration of the initial 15-day processing period, of the circumstances requiring the extension of time and the date by which the *Plan* expects to render a decision.

Extensions – Post-Service Claims

This period may be extended by the *Plan* for up to 15 days, provided that the *claims administrator* both determines that such an extension is necessary due to matters beyond the control of the *Plan* and notifies the *Plan participant*, prior to the expiration of the initial 30-day processing period, of the circumstances requiring the extension of time and the date by which the *Plan* expects to render a decision.

Calculating Time Periods

The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the *Plan*.

Notification of an Adverse Benefit Determination

The *claims administrator* shall provide a *Plan participant* with a notice, either in writing or electronically, containing the following information:

- A reference to the specific portion(s) of the Summary Plan Description upon which a denial is based;
- Specific reason(s) for a denial;
- A description of any additional information necessary for the *Plan participant* to perfect the claim and an explanation of why such information is necessary;
- A description of the *Plan's* review procedures and the time limits applicable to the procedures, including a statement of the *Plan participant's* right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on final review;
- A statement that the *Plan participant* is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the *Plan participant's* claim for benefits;
- The identity of any medical or vocational experts consulted in connection with a claim, even if the *Plan* did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);
- Any rule, guideline, protocol, or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the *Plan participant*, free of charge, upon request); and

- In the case of denials based upon a medical judgment (such as whether the treatment is *medically necessary* or *experimental*), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the *Plan* to the *Plan participant's* medical circumstances, or a statement that such explanation will be provided to the *Plan participant,* free of charge, upon request.

Appeal of Adverse Benefit Determinations

Full and Fair Review of All Claims

In cases where a claim for benefits is denied, in whole or in part, and the *Plan participant* believes the claim has been denied wrongly, the *Plan participant* may appeal the denial and review pertinent documents. The claims procedures of this *Plan* provide a *Plan participant* with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination. More specifically, the *Plan* provides:

- *Plan participants* at least 180 days following receipt of a notification of an initial adverse benefit determination within which to appeal the determination;
- *Plan participants* the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;
- For a review that does not afford deference to the previous adverse benefit determination and that is conducted by an appropriate named fiduciary of the *Plan*, who shall be neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
- For a review that takes into account all comments, documents, records, and other information submitted by the *Plan participant* relating to the claim, without regard to whether such information was submitted or considered in the prior benefit determination;
- That, in deciding an appeal of any adverse benefit determination that is based, in whole or in part, upon a medical judgment, the *Plan* fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual;
- For the identification of medical or vocational experts whose advice was obtained on behalf of the *Plan* in connection with a claim, even if the *Plan* did not rely upon their advice; and
- That a *Plan participant* will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the *Plan participant's* claim for benefits in possession of the *Plan Administrator* or the *claims administrator*; information regarding any voluntary appeals procedures offered by the *Plan*; any internal rule, guideline, protocol, or other similar criterion relied upon in making the adverse determination; and an explanation of the scientific or clinical judgment for the determination, applying the terms of the *Plan* to the *Plan participant's* medical circumstances.

Requirements for Appeal

The *Plan participant* must file the appeal in writing within 180 days following receipt of the notice of an adverse benefit determination. To file an appeal in writing, the *Plan participant's* appeal must be mailed to the *claims administrator* at:

United Medical Resources, Inc.
P.O. Box 145804
Cincinnati, Ohio 45250-5804
Attention: Appeals

It shall be the responsibility of the *Plan participant* to submit proof that the claim for benefits is covered and payable under the provisions of the *Plan*. Any appeal must include:

- The name of the *employee/Plan participant*;
- The *employee/Plan participant's* Social Security number;
- The group name or identification number;
- All facts and theories supporting the claim for benefits. **Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the *Plan participant* will lose the right to raise factual arguments and theories that support the claim if the *Plan participant* fails to include them in the appeal;**
- A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and
- Any material or information the *Plan participant* has that indicates that the *Plan participant* is entitled to benefits under the *Plan*.

It is noted that an appeal filed by a health care *provider* on behalf of a *Plan participant* is not considered an appeal under the *Plan*; all appeals must be filed by the *Plan participant.* If the *Plan participant* provides all of the required information, it may be that the expenses will be eligible for payment under the *Plan*.

Timing of Notification of Benefit Determination on Review

The *claims administrator* shall notify the *Plan participant* of the *Plan's* benefit determination on review within the following timeframes:

Pre-Service Non-Urgent Care Claims: Within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the appeal.

Concurrent Claims: Within the appropriate time period based upon the type of claim (pre-service non-urgent or post-service).

Post-Service Claims: Within a reasonable period of time, but not later than 60 days after receipt of the appeal.

Calculating Time Periods: The period of time within which the *Plan's* determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this *Plan*, without regard to whether all information necessary to make the determination accompanies the filing.

Manner and Content of Notification of Adverse Benefit Determination on Review

The *claims administrator* shall provide a *Plan participant* with notification, in writing or electronically, of a *Plan's* adverse benefit determination on review, setting forth:

- The specific reason or reasons for the denial;
- Reference to the specific portion(s) of the Summary Plan Description on which the denial is based;
- The identity of any medical or vocational experts consulted in connection with the claim, even if the *Plan* did not rely upon their advice;

- A statement that the *Plan participant* is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the *Plan participant's* claim for benefits;
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the *Plan participant* upon request;
- If the adverse benefit determination is based upon a medical judgment, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the *Plan* to the *Plan participant's* medical circumstances, will be provided free of charge upon request;
- A statement of the *Plan participant's* right to bring an action under section 502(a) of ERISA, following an adverse benefit determination on final review; and
- The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

Furnishing Documents in the Event of an Adverse Determination

In the case of an adverse benefit determination on review, the *claims administrator* shall provide such access to, and copies of, documents, records, and other information described above as appropriate.

Decision on Review to Be Final

If, for any reason, the *Plan participant* does not receive a written response to the appeal within the appropriate time period set forth above, the *Plan participant* may assume that the appeal has been denied. The decision by the *claims administrator* or other appropriate named fiduciary of the *Plan* on review will be final, binding, and conclusive, and will be afforded the maximum deference permitted by law. **All claim review procedures provided for in the *Plan* must be exhausted before any legal action is brought. Any legal action for the recovery of any benefits must be commenced within one year after the *Plan's* claim review procedures have been exhausted.**

Appointment of Authorized Representative

A *Plan participant* is permitted to appoint an authorized representative to act on his or her behalf with respect to a benefit claim or appeal of a denial. An assignment of benefits by a *Plan participant* to a *provider* will not constitute appointment of that *provider* as an authorized representative. To appoint such a representative, the *Plan participant* must complete a form that may be obtained from the *Plan Administrator* or the *claims administrator.* In the event a *Plan participant* designates an authorized representative, all future communications from the *Plan* will be with the representative, rather than the *Plan participant*, unless the *Plan participant* directs the *claims administrator,* in writing, to the contrary.

Physical Examinations

The *Plan* reserves the right to have a *physician* of its own choosing examine any *Plan participant* whose condition, *sickness,* or *injury* is the basis of a claim. All such examinations shall be at the expense of the *Plan*. This right may be exercised when and as often as the *Plan* may reasonably require during the pendency of a claim. The *Plan participant* must comply with this requirement as a necessary condition to coverage.

Autopsy

The *Plan* reserves the right to have an autopsy performed upon any deceased *Plan participant* whose condition, *sickness*, or *injury* is the basis of a claim. This right may be exercised only where not prohibited by law.

Payment of Benefits

All benefits under this *Plan* are payable, in U.S. dollars, to the covered *employee* whose *sickness* or *injury*, or whose *covered dependent's sickness* or *injury*, is the basis of a claim. In the event of the death or incapacity of a covered *employee* and in the absence of written evidence to this *Plan* of the qualification of a guardian for his or her estate, this *Plan* may, at its sole discretion, make any and all such payments to the individual or institution that, in the opinion of this *Plan*, is or was providing the care and support of such *employee*.

Assignments

Benefits for medical expenses covered under this *Plan* may be assigned by a *Plan participant* to the *provider*; however, if those benefits are paid directly to the *employee*, the *Plan* shall be deemed to have fulfilled its obligations with respect to such benefits. The *Plan* will not be responsible for determining whether any such assignment is valid. Payment of benefits that have been assigned will be made directly to the assignee unless a written request not to honor the assignment, signed by the covered *employee* and the assignee, has been received before the proof of loss is submitted.

Recovery of Payments

The *Plan* reserves the right to deduct from any benefits properly payable under this *Plan* the amount of any payment that has been made:

- In error;
- Pursuant to a misstatement contained in a proof of loss or a fraudulent act;
- Pursuant to a misstatement made to obtain coverage under this *Plan* within two years after the date such coverage commences;
- With respect to an ineligible person;
- In anticipation of obtaining a recovery in subrogation if a *Plan participant* fails to comply with the *Plan's* provisions regarding subrogation; or
- Pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational *injury* or disease to the extent that such benefits are recovered. This provision shall not be deemed to require the *Plan* to pay benefits under this *Plan* in any such instance.

The deduction may be made against any claim for benefits under this *Plan* by a covered *employee* or by any of his or her *covered dependents* if such payment is made with respect to the covered *employee* or any person covered or asserting coverage as a dependent of the covered *employee*.

Medicaid Coverage

A *Plan participant's* eligibility for any state Medicaid benefits will not be taken into account in determining or making any payments for benefits to or on behalf of such *Plan participant.* Any such benefit payments will be subject to the state's right to reimbursement for benefits it has paid on behalf of the *Plan participant,* as required by the state Medicaid program, and the *Plan* will honor any subrogation rights the state may have with respect to benefits that are payable under the *Plan*.

PLAN ADMINISTRATION

The *Plan* is administered by the *Plan Administrator* in accordance with the provisions of ERISA. An individual or entity may be appointed by the *Plan Sponsor* to be *Plan Administrator* and serve at the convenience of the *Plan Sponsor*. If the *Plan Administrator* resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the *Plan Sponsor* shall appoint a new *Plan Administrator* as soon as reasonably possible.

Notwithstanding any provisions of the *Plan Document* and this SPD to the contrary, the *Plan Sponsor* has the authority to, and hereby does, allocate certain fiduciary responsibilities to the *claims administrator.* The fiduciary responsibility allocated to the *claims administrator* is limited to authority to decide all initial claims and appeals of denied claims. In carrying out its responsibilities, the *claims administrator* may request the *Plan Administrator* to provide a written clarification on the interpretation of the *Plan.* However, the final determination of both initial claims and appeals will be determined solely by the *claims administrator.* The *claims administrator* shall have no other authority, responsibility, or liability.

The *Plan Administrator* shall establish the policies, practices, and procedures of this *Plan.* The *Plan Administrator* and the *claims administrator* shall administer this *Plan* in accordance with its terms and with ERISA. It is the express intent of this *Plan* that the *Plan Administrator* and the *claims administrator* shall have maximum legal discretionary authority to perform their respective duties set forth below. The decisions of the *Plan Administrator* and/or the *claims administrator* shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this *Plan* will be paid only if the *claims administrator* decides, at its discretion, that the *Plan participant* is entitled to them.

Duties of the Plan Administrator

The duties of the *Plan Administrator* include the following:

- To administer the *Plan* in accordance with its terms;
- To interpret the *Plan*, including the authority to construe possible ambiguities, inconsistencies, omissions, and disputed terms;
- To prescribe procedures for filing a claim for benefits;
- To keep and maintain the *Plan* documents and all other records pertaining to the *Plan*;
- To appoint and supervise a third party administrator to pay claims;
- To perform all necessary reporting as required by ERISA;
- To establish and communicate procedures to determine whether a *medical child support order* is a *QMCSO*;
- To delegate to any person or entity such powers, duties, and responsibilities as it deems appropriate; and
- To perform each and every function necessary for or related to the *Plan's* administration.

Duties of the Claims Administrator

The *claims administrator* shall have the following duties with respect to all initial claims and all appeals of denied claims:

- To administer the *Plan* in accordance with its terms;

Plan Administration

- To determine all questions of eligibility, status, and coverage under the *Plan*;
- To make factual findings;
- To decide disputes that may arise relative to a *Plan participant's* rights;
- To decide all initial claims, to review all appeals, and to uphold or reverse any such denials; and
- To keep and maintain records pertaining to such claims and appeals.

ERISA INFORMATION

This *Plan*, regulated by the Employee Retirement Income Security Act of 1974 (ERISA), is required to make available to all *Plan participants* specific information about the *Plan*. The following sections describe basic *Plan* information and your rights under ERISA.

Plan Name

Lexington Precision Corporation Group Medical Care Plan

Plan Sponsor and Plan Administrator

Lexington Precision Corporation
30195 Chagrin Boulevard, Suite 208W
Cleveland, Ohio 44124-5703
216-591-1070

Plan Sponsor's identification number: 22-1830121

Please contact the *Plan Administrator* for a complete list of *employers* participating in the Lexington Precision Corporation Group Medical Care Plan. This list is also available for examination as required by federal law.

Plan Type and Number

This is a group health plan that offers hospitalization, medical, and prescription drug benefits. The *Plan* number is 510.

This *Plan* provides benefits for medical expenses *incurred* as a result of an *accidental injury*, *injury*, *illness*, or *sickness*. It does not provide benefits for the actual *accidental injury*, *injury*, *illness*, or *sickness*.

Plan Effective Date

The effective date of the amended *Plan* as described in this Summary Plan Description is January 1, 2005.

Eligible Participants

Please refer to the ELIGIBILITY AND ENROLLMENT section.

Claims Administrator

United Medical Resources, Inc.
P.O. Box 145804
Cincinnati, Ohio 45250-5804

513-619-3000
Cincinnati and Northern Kentucky
1-800-950-4867 Toll-Free

Collective Bargaining Unit

This *Plan* is made available to some *employees* who are members of a collective bargaining unit. A copy of the collective bargaining agreement is available upon written request to the *Plan Administrator.* In addition, it is available for examination as required by federal law.

Plan Funding

This *Plan* is self-funded by contributions from the *Plan Sponsor* and the *employees*. Benefits are paid from the general assets of the *Plan Sponsor*. *Employee* contributions are calculated annually and are used to pay claims.

Plan Service of Legal Process

The *Plan's* agent for service of legal process is:

Lexington Precision Corporation
Plan Administrator
30195 Chagrin Boulevard, Suite 208W
Cleveland, Ohio 44124-5703
Attn.: Chief Financial Officer

This *Plan* is a legal entity. Service of legal process may be made upon the *Plan Administrator*.

Benefit Records — Calendar Year

The benefit records are kept January 1 through December 31 for processing claims.

Plan Records — Plan Year

The fiscal records are kept January 1 through December 31 for Department of Labor reporting.

Benefit Committee

The members of the Benefit Committee (*employees* of Lexington Precision Corporation) are as follows:

Human Resources Manager
Senior Vice President & Chief Financial Officer
Treasurer
Controller, Lexington Medical

Lexington Precision Corporation
30195 Chagrin Boulevard, Suite 208W
Cleveland, Ohio 44124-5703

Administration of Plan

The *Plan* is a self-insured welfare benefit plan established pursuant to, and governed by, ERISA. *UMR* is not an insurance company or carrier, but merely provides certain services on behalf of the *Plan*. The *Plan Sponsor* has a stop loss, or excess loss, insurance policy to finance large claims under the *Plan*. The stop loss carrier does not directly pay benefits of the *Plan*. Rather, the insurance carrier pays the *Plan Sponsor* consistent with the self-insured status of the *Plan,* and the use of stop loss is merely a means of financing by the *Plan Sponsor.*

Plan Document

The *Plan* has a legal document called the *Plan Document*. A copy of the *Plan Document* is available upon written request to the *Plan Administrator,* who may make a reasonable charge for the copies.

Statement of ERISA Rights

As a participant in the *Plan*, you are entitled to certain rights and protections under ERISA. ERISA provides that all *Plan participants* shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the *Plan Administrator's* office and at other specified locations, such as worksites and union halls, all documents governing the *Plan*, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the *Plan* with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the *Plan Administrator,* copies of documents governing the operation of the *Plan,* including insurance contracts, collective bargaining agreements, copies of the latest annual report (Form 5500 Series), and copies of the updated Summary Plan Description. The *Plan Administrator* may make a reasonable charge for the copies.
- Receive a summary of the *Plan's* annual financial report. The *Plan Administrator* is required by law to furnish each *Plan participant* with a copy of this summary annual report.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, your *spouse,* or your dependents if there is a loss of coverage under the *Plan* as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the *Plan* on the rules governing your COBRA continuation coverage rights.
- Reduction or elimination of exclusionary periods of coverage for *pre-existing conditions* under your group health plan, if you have *creditable coverage* from another plan. You should be provided a certificate of *creditable coverage,* free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of *creditable coverage,* you may be subject to a *pre-existing condition* exclusion for up to 12 months after your *enrollment date* in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for *Plan participants*, ERISA imposes duties upon the people who are responsible for the operation of the *Plan*. The people who operate your *Plan*, called "fiduciaries" of the *Plan*, have a duty to do so prudently and in the interest of you and other *Plan participants* and beneficiaries. No one, including your *employer* or your union, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of *Plan* documents or the latest annual report from the *Plan* and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the *Plan Administrator* to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the *Plan Administrator*. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the *Plan's* decision or lack thereof concerning the qualified status of a domestic relations order or a *medical child support order*, you may file suit in federal court. If it should happen that *Plan* fiduciaries misuse the *Plan's* money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in

a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order **you** to pay these costs and fees (for example, if it finds your claim is frivolous).

Assistance With Your Questions

If you have any questions about your *Plan,* contact the *Plan Administrator*.

If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the *Plan Administrator,* contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Plan Modification, Amendment, and Termination

The *Plan Sponsor* has established this *Plan* with the intention of maintaining it for an indefinite period of time. However, the *Plan Sponsor* may, at its sole discretion, at any time, amend or terminate the *Plan,* in whole or in part. This includes the right, at its sole discretion:

- to amend or terminate this *Plan,* in whole or in part, at any time.
- to change, increase, or decrease *Plan* contributions (if any), in whole or in part, at any time.

No consent is required on the part of any *Plan participant* for the *Plan Sponsor* to take any of the actions indicated above.

The preceding provisions shall apply regardless of any oral or written statement to any person to the contrary.

Any such amendment to the *Plan* shall be enacted, if the *Plan Sponsor* is a corporation, by the approval of an executive officer of the *Plan Sponsor*, acting on behalf of the *Company* and with the agreement of the Benefit Committee, and in accordance with applicable federal and state law. Termination of the *Plan* shall be enacted, if the *Plan Sponsor* is a corporation, by resolution of the *Plan Sponsor*'s board of directors and in accordance with applicable federal and state law. Notice shall be provided as required by ERISA. In the event that the *Plan Sponsor* is a different type of entity, then such amendment or termination shall be taken and enacted in accordance with applicable federal and state law and any applicable governing documents. In the event that the *Plan Sponsor* is a sole proprietorship, then such action shall be taken by the sole proprietor, at his or her sole discretion.

If the *Plan* is terminated, the rights of the *Plan participants* are limited to expenses *incurred* before termination. All amendments to the *Plan* shall be effective as of a date established by the *Plan Sponsor.*

HIPAA PRIVACY AND SECURITY

Notice Of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This Notice of Privacy Practices ("Notice") is made in compliance with the Standards for Privacy of Individually Identifiable Health Information (the "Privacy Standards") set forth by the U.S. Department of Health and Human Services ("HHS") pursuant to the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"). The Lexington Precision Corporation Group Health Care Plan (the "*Plan*") is required by law to take reasonable steps to ensure the privacy of your Protected Health Information ("PHI"), as defined below, and to inform you about:

(1) the *Plan's* uses and disclosures of PHI;

(2) your privacy rights with respect to your PHI;

(3) the *Plan's* duties with respect to your PHI;

(4) your right to file a complaint with the *Plan* and with the Secretary of HHS; and

(5) the person or office to contact for further information about the *Plan's* privacy practices.

The term "**Protected Health Information**" (PHI) includes all "Individually Identifiable Health Information" transmitted or maintained by the *Plan*, regardless of form (oral, written, or electronic).

The term "**Individually Identifiable Health Information**" means information that:

- Is created or received by a health care *provider*, health plan, employer, or health care clearinghouse;
- Relates to the past, present, or future physical or *mental health* or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and
- Identifies the individual, or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

Section 1. Notice of PHI Uses and Disclosures

1.1 Required PHI Disclosures

Upon your request, the *Plan* is required to give you access to certain PHI to inspect and copy it and to provide you with an accounting of disclosures of PHI made by the *Plan*. For further information pertaining to your rights in this regard, see Section 2 of this Notice.

The *Plan* must disclose your PHI when required by the Secretary of HHS to investigate or determine the *Plan's* compliance with the Privacy Standards.

1.2 Permitted uses and disclosures to carry out treatment, payment, and health care operations

The *Plan*, its business associates, and their agents/subcontractors, if any, will use or disclose PHI without your consent, authorization, or opportunity to agree or object, to carry out treatment, payment, and health care operations. The *Plan* will disclose PHI to a business associate only if the *Plan* receives satisfactory assurance that the business associate will appropriately safeguard the information.

In addition, the *Plan* may contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you. The *Plan* will disclose PHI to Lexington Precision Corporation ("*Plan Sponsor*") for purposes related to treatment, payment, and health care

operations. The *Plan Sponsor* has amended its plan documents to protect your PHI as required by the Privacy Standards. The *Plan Sponsor* will obtain an authorization from you if it intends to use or disclose your PHI for purposes unrelated to treatment, payment, and health care operations.

Treatment is the provision, coordination, or management of health care and related services by one or more health care *providers*. It also includes, but is not limited to, consultations and referrals between one or more of your *providers*.

> For example, the *Plan* may disclose to a treating orthodontist the name of your treating *dentist* so that the orthodontist may ask for your dental X-rays from the treating *dentist*.

Payment means activities undertaken by the *Plan* to obtain premiums or to determine or fulfill its responsibility for coverage and provision of benefits under the *Plan*, or to obtain or provide reimbursement for the provision of health care. Payment includes, but is not limited to, actions to make eligibility or coverage determinations, billing, claims management, collection activities, subrogation, reviews for *medical necessity* and appropriateness of care, utilization review, and pre-authorizations.

> For example, the *Plan* may tell a doctor whether you are eligible for coverage or what percentage of the bill might be paid by the *Plan*.

Health care operations means conducting quality assessment and improvement activities, population-based activities relating to improving health or reducing health care costs, contacting health care *providers* and patients with information about treatment alternatives, reviewing the competence or qualifications of health care professionals, evaluating health plan performance, underwriting, premium rating, and other insurance activities relating to creating, renewing, or replacing health insurance contracts or health benefits. It also includes disease management, case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse detection and compliance programs, business planning and development, business management, and general administrative activities.

> For example, the *Plan* may use information about your claims to refer you to a disease management program, project future benefit costs, or audit the accuracy of its claims processing functions.

1.3 Uses and disclosures that require your written authorization

Your written authorization generally will be obtained before the *Plan* will use or disclose psychotherapy notes about you from your psychotherapist. Psychotherapy notes are separately filed notes about your conversations with your *mental health* professional during a counseling session. They do not include summary information about your *mental health* treatment. The *Plan* may use and disclose such notes without authorization when needed by the *Plan* to defend against litigation filed by you.

1.4 Disclosures that require that you be given an opportunity to agree or disagree prior to the disclosure

The *Plan* may disclose to a family member, other relative, close personal friend of yours, or any other person identified by you PHI directly relevant to such person's involvement with your care or payment for your health care when you are present for, or otherwise available prior to, a disclosure and you are able to make health care decisions, if:

- The *Plan* obtains your agreement;
- The *Plan* provides you with the opportunity to object to the disclosure and you fail to do so; or
- The *Plan* infers from the circumstances, based upon professional judgment, that you do not object to the disclosure.

The *Plan* may obtain your oral agreement or disagreement to a disclosure.

However, if you are not present, or the opportunity to agree or object to the disclosure cannot practicably be provided because of your incapacity or an *emergency* circumstance, the *Plan* may, in the exercise of professional judgment, determine whether the disclosure is in your best interests, and, if so, disclose only PHI that is directly relevant to the person's involvement with your health care.

1.5 Uses and disclosures for which authorization or opportunity to agree or object is not required

Use and disclosure of your PHI is allowed without your authorization or opportunity to agree or object under the following circumstances:

(a) When required by law, provided that the use or disclosure complies with and is limited to the relevant requirements of such law.

(b) When permitted for purposes of public health activities, including disclosures to (i) a public health authority or other appropriate government authority authorized by law to receive reports of child abuse or neglect and (ii) a person subject to the jurisdiction of the Food and Drug Administration (FDA) regarding an FDA-regulated product or activity for the purpose of activities related to the quality, safety, or effectiveness of such FDA-regulated product or activity, including to report product defects, to permit product recalls, and to conduct post-marketing surveillance. PHI also may be disclosed to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition, if authorized by law.

(c) Except for reports of child abuse or neglect permitted by part (b) above, when required or authorized by law, or with your agreement, the *Plan* may disclose PHI about you to a government authority, including a social service or protective services agency, if the *Plan* reasonably believes you to be a victim of abuse, neglect, or domestic violence. In such case, the *Plan* will promptly inform you that such a disclosure has been or will be made unless (i) the *Plan* believes that informing you would place you at risk of serious harm or (ii) the *Plan* would be informing your personal representative, and the *Plan* believes that your personal representative is responsible for the abuse, neglect, or other *injury*, and that informing such person would not be in your best interests. For the purposes of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure generally may be made to the minor's parents or other representatives although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's PHI.

(d) The *Plan* may disclose your PHI to a health oversight agency for oversight activities authorized by law. This includes civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against *providers*); and other activities necessary for appropriate oversight of: (i) the health care system, (ii) government benefit programs for which health information is relevant to beneficiary eligibility, (iii) entities subject to government regulatory programs for which health information is needed to determine compliance with program standards, or (iv) entities subject to civil rights laws for which health information is needed to determine compliance.

(e) The *Plan* may disclose your PHI in the course of a judicial or administrative proceeding in response to an order of a court or administrative tribunal, provided that the *Plan* discloses only the PHI expressly authorized by such order, or in response to a subpoena, discovery request, or other lawful process, that is not accompanied by an order of a court of administrative tribunal if certain conditions are met. One of those conditions is that satisfactory assurances must be given to the *Plan* that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection, and the time to object has expired and either no objections were raised or any objections were resolved in favor of disclosure by the court or tribunal.

(f) The *Plan* may disclose your PHI to a law enforcement official when required for law enforcement purposes. The *Plan* may disclose PHI as required by law, including laws that require the reporting of certain types of wounds. Also, the *Plan* may disclose PHI in compliance with (i) a court order, court-ordered warrant, or a subpoena or summons issued by a judicial officer, (ii) a grand jury subpoena, or (iii) an administrative request, including an administrative subpoena or summons, a civil or authorized investigative demand, provided certain conditions are satisfied. PHI may be disclosed for law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person. Under certain circumstances, the *Plan* may disclose your PHI in response to a law enforcement official's request if you are, or are suspected to be, a victim of a crime. Further, the *Plan* may disclose your PHI if it believes in good faith that the PHI constitutes evidence of criminal conduct that occurred on the *Plan's* premises.

(g) The *Plan* may disclose PHI to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.

(h) The *Plan* may use or disclose PHI for research, subject to certain conditions.

(I) When consistent with applicable law and standards of ethical conduct, the *Plan* may use or disclose PHI if the *Plan*, in good faith, believes the use or disclosure: (i) is necessary to prevent or lessen a serious and imminent threat to health or safety of a person or the public and is to person(s) able to prevent or lessen the threat, including the target of the threat, or (ii) is needed for law enforcement authorities to identify or apprehend an individual, provided certain requirements are met.

(j) When authorized by and to the extent necessary to comply with Workers' Compensation or other similar programs established by law.

Except as otherwise indicated in this Notice, uses and disclosures will be made only with your written authorization, subject to your right to revoke such authorization. You may revoke an authorization at any time, provided your revocation is done in writing, except to the extent that the *Plan* has taken action in reliance upon the authorization, or if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

Section 2: Rights of Individuals

2.1 Right to Request Restrictions on PHI Uses and Disclosures

You may request the *Plan* to restrict uses and disclosures of your PHI to carry out treatment, payment, or health care operations, or to restrict disclosures to family members, relatives, friends, or other persons identified by you who are involved in your care or payment for your care. However, the *Plan* is not required to agree to your requested restriction.

If the *Plan* agrees to a requested restriction, the *Plan* may not use or disclose PHI in violation of such restriction, except that, if you requested a restriction and later are in need of *emergency* treatment and the restricted PHI is needed to provide the *emergency* treatment, the *Plan* may use the restricted PHI, or it may disclose such information to a health care *provider*, to provide such treatment to you. If restricted PHI is disclosed to a health care *provider* for *emergency* treatment, the *Plan* must request that such health care *provider* not further use or disclose the information.

A restriction agreed to by the *Plan* is not effective to prevent uses or disclosures when required by the Secretary of HHS to investigate or determine the *Plan's* compliance with the Privacy Standards or uses or disclosures that are otherwise required by law.

The *Plan* may terminate its agreement to a restriction, if:

- You agree to or request the termination in writing;
- You orally agree to the termination and the oral agreement is documented; or
- The *Plan* informs you that it is terminating its agreement to a restriction, except that such termination is only effective with respect to PHI created or received after the *Plan* has informed you of the termination.

If the *Plan* agrees to a restriction, it will document the restriction by maintaining a written or electronic record of the restriction. The record of the restriction will be retained for six years from the date of its creation or the date when it last was in effect, whichever is later.

You or your personal representative will be required to request restrictions on uses and disclosures of your PHI in writing. Such requests should be addressed to the following individual: Treasurer, 30195 Chagrin Boulevard, Suite 208W, Cleveland, Ohio, 44124, 216-591-1070.

2.2 Right to Request Confidential Communications of PHI

You may request to receive communications of PHI from the *Plan* by alternative means or at alternative locations if you clearly state that the disclosure of all or part of the information to which the request pertains could endanger you. The *Plan* will accommodate all such reasonable requests. However, the *Plan* may condition the provision of a reasonable accommodation on:

- When appropriate, information as to how payment, if any, will be handled; and
- Specification by you of an alternative address or other method of contact.

You or your personal representative will be required to request confidential communications of your PHI in writing. Such requests should be addressed to the following individual: Treasurer, 30195 Chagrin Boulevard, Suite 208W, Cleveland, Ohio, 44124, 216-591-1070.

2.3 Right to Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the *Plan* maintains PHI in the designated record set.

"**Designated Record Set**" means a group of records maintained by or for a health plan that is enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or used in whole or in part by or for the health plan to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set.

The *Plan* will act on a request for access no later than 30 days after receipt of the request. However, if the request for access is for PHI that is not maintained or accessible to the *Plan* on-site, the *Plan* must take action no later than 60 days from the receipt of such request. The *Plan* must take action as follows: If the *Plan* grants the request, in whole or in part, the *Plan* must inform you of the acceptance and provide the access requested. However, if the *Plan* denies the request, in whole or in part, the *Plan* must provide you with a written denial. If the *Plan* cannot take action within the required time, the *Plan* may extend the time for such action by no more than 30 days if the *Plan*, within the applicable time limit, provides you with a written statement of the reasons for the delay and the date by which it will complete its action on the request.

If the *Plan* provides access to PHI, it will provide the access requested, including inspection or obtaining a copy, or both, of your PHI in a designated record set. The *Plan* will provide you with access to the PHI in the form or format requested if it is readily producible in such form or format; or, if it is not, in a readable hard copy form or such other form or format as agreed to between you and the *Plan*. The *Plan*

may provide you with a summary of the PHI requested, in lieu of providing access to the PHI or may provide an explanation of the PHI to which access has been provided in certain circumstances. The *Plan* will arrange with you for a convenient time and place to inspect or obtain a copy of the PHI, or mail a copy of the PHI at your request. If you request a copy of PHI or agree to a summary or explanation of PHI, the *Plan* may impose a reasonable, cost-based fee.

If the *Plan* denies access to PHI in whole or in part, the *Plan* will, to the extent possible, give you access to any other PHI requested, after excluding PHI as to which the *Plan* has grounds to deny access. If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, if applicable, a statement of your review rights, including a description of how you may exercise those review rights, and a description of how you may complain to the *Plan* or to the Secretary of the HHS. If you request review of a decision to deny access, the *Plan* will refer the request to a designated licensed health care professional for review. The reviewing official will determine, within a reasonable period of time, whether to deny the access requested. The *Plan* will promptly provide you with written notice of that determination.

If the *Plan* does not maintain the PHI that is the subject of your request for access, and the *Plan* knows where the requested information is maintained, the *Plan* will inform you where to direct the request for access.

You or your personal representative will be required to request access to your PHI in writing. Such requests should be addressed to the following individual: Treasurer, 30195 Chagrin Boulevard, Suite 208W, Cleveland, Ohio, 44124, 216-591-1070.

2.4 Right to Amend PHI

You have the right to request the *Plan* to amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set.

The *Plan* may deny your request for amendment if it determines that the PHI or record that is the subject of the request:

- Was not created by the *Plan*, unless you provide a reasonable basis to believe that the originator of PHI is no longer available to act on the requested amendment;
- Is not part of the designated record set;
- Would not be available for your inspection under the Privacy Standards; or
- Is accurate and complete.

The *Plan* has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the *Plan* is unable to comply within that deadline provided that the *Plan*, within the original 60-day time period, gives you a written statement of the reasons for the delay and the date by which it will complete its action on the request. If the *Plan* accepts the requested amendment, the *Plan* will make the appropriate amendment to the PHI or record that is the subject of the request by, at a minimum, identifying the records in the designated record set that are affected by the amendment and appending or otherwise providing a link to the location of the amendment. The *Plan* will timely inform you that the amendment is accepted and obtain your identification of and agreement to have the *Plan* notify the relevant persons with which the amendment needs to be shared as provided in the Privacy Standards.

If the request is denied in whole or part, the *Plan* must provide you with a written denial that (i) explains the basis for the denial, (ii) sets forth your right to submit a written statement disagreeing with the denial and how to file such a statement, (iii) states that, if you do not submit a statement of disagreement, you may request that the *Plan* provide your request for amendment and the denial with any future disclosures of the PHI that is the subject of the amendment, and (iv) includes a description of how you may complain to the *Plan* or to the Secretary of HHS. The *Plan* may reasonably limit the length of a statement of

disagreement. Further, the *Plan* may prepare a written rebuttal to a statement of disagreement, which will be provided to you. The *Plan* must, as appropriate, identify the record or PHI in the designated record set that is the subject of the disputed amendment and append or otherwise link your request for an amendment, the *Plan's* denial of the request, your statement of disagreement, if any, and the *Plan's* rebuttal, if any, to the designated record set. If a statement of disagreement has been submitted, the *Plan* will include the above-referenced material, or, at the *Plan's* election, an accurate summary of such information, with any subsequent disclosure of the PHI to which the disagreement relates. If you do not submit a written statement of disagreement, the *Plan* must include your request for amendment and its denial, or an accurate summary of such information with any subsequent disclosure of the PHI only if requested by you.

You or your personal representative will be required to request amendment to your PHI in a designated record set in writing. Such requests should be addressed to the following individual: Treasurer, 30195 Chagrin Boulevard, Suite 208W, Cleveland, Ohio, 44124, 216-591-1070.

All requests for amendment of PHI must include a reason to support the requested amendment.

2.5 Right to Receive an Accounting of PHI Disclosures

At your request, the *Plan* will provide you with an accounting of disclosures by the *Plan* of your PHI during the six years prior to the date on which the accounting is requested. However, such accounting need not include PHI disclosures made: (a) to carry out treatment, payment, or health care operations; (b) to individuals about their own PHI; (c) incident to a use or disclosure otherwise permitted or required by the Privacy Standards; (d) pursuant to an authorization; (e) to certain persons involved in your care or payment for your care; (f) to notify certain persons of your location, general condition, or death; (g) as part of a "Limited Data Set" (as defined in the Privacy Standards), which largely relates to research purposes; or (h) prior to the compliance date of April 14, 2003. You may request an accounting of disclosures for a period of time less than six years from the date of the request.

The accounting will include disclosures of PHI that occurred during the six years (or such shorter time period, if applicable) prior to the date of the request for an accounting, including disclosures to or by business associates of the *Plan*. Except as otherwise provided below, for each disclosure, the accounting will include:

- The date of the disclosure;
- The name of the entity or person who received the PHI and, if known, the address of such entity or person;
- A brief description of the PHI disclosed; and
- A brief statement of the purpose of the disclosure that reasonably informs you of the basis for the disclosure, or, in lieu of such statement, a copy of a written request for disclosure.

If during the period covered by the accounting, the *Plan* has made multiple disclosures of PHI to the same person or entity for a single purpose, the accounting may, with respect to such multiple disclosures, provide the above-referenced information for the first disclosure; the frequency, periodicity, or number of the disclosures made during the accounting period; and the date of the last disclosure.

If during the period covered by the accounting, the *Plan* has made disclosures of PHI for a particular research purpose for 50 or more individuals, the accounting may, with respect to such disclosures for which your PHI may have been included, provide certain information as permitted by the Privacy Standards. If the *Plan* provides an accounting for such research disclosures, and if it is reasonably likely that your PHI was disclosed for such research activity, the *Plan* shall, at your request, assist in contacting the entity that sponsored the research and the researcher.

If the accounting cannot be provided within 60 days after receipt of the request, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request more than one accounting within a 12-month period, the *Plan* will charge a reasonable, cost-based fee for each subsequent accounting unless you withdraw or modify the request for a subsequent accounting to avoid or reduce the fee.

You or your personal representative will be required to request an accounting of your PHI disclosures in writing. Such requests should be addressed to the following individual: Treasurer, 30195 Chagrin Boulevard, Suite 208W, Cleveland, Ohio, 44124, 216-591-1070.

2.6 The Right To Receive a Paper Copy of This Notice Upon Request

You have a right to obtain a paper copy of this Notice upon request. To request a paper copy of this Notice, contact the following individual: Treasurer, 30195 Chagrin Boulevard, Suite 208W, Cleveland, Ohio, 44124, 216-591-1070.

2.7 A Note About Personal Representatives

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his or her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may include, but is not limited to, the following:

(a) a power of attorney for health care purposes, notarized by a notary public;

(b) a court order of appointment of the person as the conservator or guardian of the individual; or

(c) an individual who is the parent of a minor child.

The *Plan* retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

Section 3: The Plan's Duties

3.1 Notice

The *Plan* is required by law to maintain the privacy of PHI and to provide individuals (participants and beneficiaries) with notice of its legal duties and privacy practices with respect to PHI.

This Notice is effective beginning on April 14, 2003, and the *Plan* is required to comply with the terms of this Notice. However, the *Plan* reserves the right to change the terms of this Notice and to make the new revised notice provisions effective for all PHI that it maintains, including any PHI created, received, or maintained by the *Plan* prior to the date of the revised notice. If a privacy practice is changed, a revised version of this Notice will be provided to all individuals then covered by the *Plan*. If agreed upon between the *Plan* and you, the *Plan* will provide you with a revised Notice electronically. Otherwise, the *Plan* will mail a paper copy of the revised Notice to your home address. In addition, the revised Notice will be maintained on any web site maintained by the *Plan* to provide information about its benefits.

Any revised version of this Notice will be distributed within 60 days of any material change to the uses or disclosures, the individual's rights, the duties of the *Plan*, or other privacy practices stated in this Notice. Except when required by law, a material change to any term of this Notice may not be implemented prior to the effective date of the revised notice in which such material change is reflected.

3.2 Minimum Necessary Standard

When using or disclosing PHI or when requesting PHI from another covered entity, the *Plan* will make reasonable efforts not to use, disclose, or request more than the minimum amount of PHI necessary to

accomplish the intended purpose of the use, disclosure, or request, taking into consideration practical and technological limitations.

However, the minimum necessary standard will not apply in the following situations:

(a) disclosures to or requests by a health care *provider* for treatment;

(b) uses or disclosures made to the individual;

(c) disclosures made to the Secretary of HHS;

(d) uses or disclosures that are required by law;

(e) uses or disclosures that are required for the *Plan's* compliance with the Privacy Standards; and

(f) uses or disclosures made pursuant to an authorization.

This Notice does not apply to information that has been de-identified. De-identified information is health information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual. It is not individually identifiable health information.

In addition, the *Plan* may use or disclose "summary health information" to the *Plan Sponsor* for obtaining premium bids or modifying, amending, or terminating the group health plan. Summary health information summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan, and from which identifying information has been deleted in accordance with the Privacy Standards.

3.3 Disclosure of Electronic PHI to the Plan Sponsor for Plan Administration Functions

To enable the *Plan Sponsor* to receive and use electronic PHI for *Plan* administration functions (as defined in 45 CFR 164.504(a)), the *Plan Sponsor* agrees to:

- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of the *Plan*;
- Ensure that adequate separation between the *Plan* and the *Plan Sponsor*, as required in 45 CFR 164.504(f)(2)(iii), is supported by reasonable and appropriate security measures;
- Ensure that any agent, including a subcontractor, to whom the *Plan Sponsor* provides electronic PHI created, received, maintained, or transmitted on behalf of the *Plan*, agrees to implement reasonable and appropriate security measures to protect the electronic PHI; and
- Report to the *Plan* any security incident of which it becomes aware.

Any terms not otherwise defined in this Summary Plan Description shall have the meanings set forth in the Security Standards.

Section 4: Your Right to File a Complaint With the Plan or the HHS Secretary

If you believe that your privacy rights have been violated, you may complain to the *Plan*. Any complaint must be in writing and addressed to the following individual: Chief Financial Officer, 30195 Chagrin Boulevard, Suite 208W, Cleveland, Ohio, 44124, 216-591-1070.

You also may file a complaint with the Secretary of the U.S. Department of Health and Human Services, by writing to him at the following address: The Hubert H. Humphrey Building, 200 Independence Avenue, S.W., Washington, D.C. 20201.

The *Plan* will not retaliate against you for filing a complaint.

Section 5: Whom to Contact at the Plan for More Information

If you have any questions regarding this Notice or the subjects addressed in it, you may contact the following individual: Treasurer, 30195 Chagrin Boulevard, Suite 208W, Cleveland, Ohio, 44124, 216-591-1070.

Conclusion

PHI use and disclosure by the *Plan* is regulated by a federal law known as HIPAA. You may find these rules at 45 "Code of Federal Regulations" Parts 160 and 164. This Notice attempts to summarize the Privacy Standards. The Privacy Standards will supersede any discrepancy between the information in this Notice and the Privacy Standards.

MISCELLANEOUS INFORMATION

Conformity With Applicable Laws

This *Plan* shall be deemed to be amended automatically to conform as required by any applicable law, regulation, or order or judgment of a court of competent jurisdiction governing provisions of this *Plan*, including, but not limited to, stated maximums, exclusions, or limitations. In the event that any law, regulation, or order or judgment of a court of competent jurisdiction causes the *claims administrator* to pay claims that are otherwise limited or excluded under this *Plan*, such payments will be considered as being in accordance with the terms of this Summary Plan Description. It is intended that the *Plan* will conform to the requirements of ERISA, as it applies to employee welfare plans, as well as any other applicable law.

Fraud

The following actions by any *Plan participant*, or a *Plan participant's* knowledge of such actions being taken by another, constitute fraud and will result in immediate termination of all coverage under this *Plan* for the entire *family* of which the *Plan participant* is a member:

- Attempting to submit a claim for benefits (including attempting to fill a prescription) for a person who is not a *Plan participant* in the *Plan*;
- Attempting to file a claim for a *Plan participant* for services that were not rendered or drugs or other items that were not provided;
- Providing false or misleading information in connection with enrollment in the *Plan*; or
- Providing any false or misleading information to the *Plan*.

Headings

The headings used in this Summary Plan Description are used for convenience of reference only. *Plan participants* are advised not to rely on any provision because of the heading.

Liability of Benefit Committee

No member of the Benefit Committee shall incur any liability for any action or failure to act excepting only liability for his or her own breach of fiduciary duty. To the extent not covered by insurance, the *employer* and each participating *employer* shall indemnify each member of the Benefit Committee and any *employee* acting on the Benefit Committee's behalf against any and all claims, loss, damages, and liability arising from any action or failure to act.

No Waiver or Estoppel

No term, condition, or provision of this *Plan* shall be deemed to have been waived, and there shall be no estoppel against the enforcement of any provision of this *Plan*, except by written instrument of the party charged with such waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless specifically stated therein, and each such waiver shall operate only as to the specific term or condition waived and shall not constitute a waiver of such term or condition for the future or as to any act other than the one specifically waived.

Right to Receive and Release Information

For the purpose of determining the applicability of and implementing the terms of these benefits, the *Plan Administrator* and/or the *claims administrator* may, without the consent of or notice to any person, release or obtain any information necessary to determine the acceptability of any applicant or *Plan participant* for benefits from this *Plan*. In so acting, the *Plan Administrator* and/or the *claims administrator* shall be free from any liability that may arise with regard to such action. Any *Plan participant* claiming benefits under this *Plan* shall furnish to the *Plan Administrator* and/or the *claims administrator* such information as may be necessary to implement this provision.

Right of Recovery

Whenever payments have been made by this *Plan* in a total amount, at any time, in excess of the maximum amount of benefits payable under this *Plan*, the *Plan* shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this *Plan* shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations that the *Plan* determines are responsible for payment of such amount, and any future benefits payable to the *Plan participant*.

Contributions

Participant Contributions

Periodically, the *Plan Administrator* shall determine, or cause to be determined, the amount, if any, that must be contributed by eligible persons in order to receive benefits under the *Plan*. As of the earliest date on which they can reasonably be segregated from the *employer's* general assets, but in any event no later than 90 days after the date on which they are received by the *employer* (in the case of amounts which are paid by a *Plan participant* to an *employer*) or otherwise would have been payable to a *Plan participant* in cash (in the case of amounts withheld from a *Plan participant's* wages), participant contributions shall be applied to the payment of claims, premiums, or other amounts required to provide coverage or benefits under the *Plan*.

Employer Contributions

To the extent required after application of participant contributions, the *employer* shall contribute an *employer* contribution to the *Plan* in an amount sufficient to provide benefits thereunder.

Facility of Payment

Payment to Provider

At the election of the *claims administrator*, benefits under this *Plan* may be paid directly to the *provider*.

Payment to Another Individual

If, in the opinion of the *claims administrator*, a valid release cannot be obtained for the payment of any benefits payable under this *Plan*, the *claims administrator* may, at its option, make such payment to the individual or individuals who have, in its opinion, assumed the care and principal support of the *Plan participant* and who are, therefore, equitably entitled thereto.

Death of Plan Participant

In the event of the death of the *Plan participant* prior to such time as all benefit payments due hereunder have been made, the *claims administrator* may, at its sole discretion and option, honor benefit assignments, if any, made prior to the death of the *Plan participant*. Any payment directed to be made by

the *claims administrator* in accordance with the provisions of this section shall fully discharge the *Plan* to the extent of such payments.

Payment of Claims

Current claims received in any one month may be accumulated for later payment, and, in the event of such procedure and there ultimately being insufficient funds to pay in full such claims accumulated for a month after payment of expenses, the funds remaining on hand may be distributed proportionately among those claims accumulated for such month. The *Plan* shall incur no liability for failure to make payment of any claim or to make ratable distribution on any claim without regard to the reasons therefor, the *claims administrator* having the responsibility for determining claims and directing payment thereof.

Offset

In the event any payment is made by the *Plan* to an individual who is not entitled to such payment, or in the event the amount of such payment is incorrect, the *Plan* shall have the right to reduce future payments due to such person by the amount of such erroneous payment. This right to offset shall not limit the rights of the *Plan* to recover such erroneous payments in any other manner.

Reservation of Rights by the Employer and Limitations on Rights of Participants

Nature of Obligation to Continue Employer Contributions

Although it is the intention of the *employer* that this *Plan* shall be continued and contributions made regularly, the *Plan* is entirely voluntary on the part of the *employer*, and the continuance of the *Plan* and the payments thereunder are not assumed as a contractual obligation of the *employer*.

Plan Not Contract of Employment

This *Plan* shall not be deemed to constitute a contract between the *employer* and any *Plan participant* or to be a consideration or an inducement for the employment of any eligible person. Nothing contained in this *Plan* shall be deemed to give any eligible person the right to be retained in the service of the *employer* or to interfere with the right of the *employer* to discharge any eligible person at any time regardless of the effect which such discharge shall be upon him or her as a *Plan participant*.

Suspension or Termination of Plan

The *employer* may suspend or terminate this *Plan* at any time. Except to the extent otherwise specifically provided by the *employer*, in the event of the termination of the *Plan*, the *employer* shall have no liability for claims *incurred* subsequent to the date of termination.

Conformity With Statutes

Any provision of the *Plan* which, on its effective date, is in conflict with the statutes of the United States, is hereby amended to conform to the minimum requirements of such statutes.

Plan Assets

Except as otherwise required by ERISA, other applicable law, and regulations thereunder, no assets of this *Plan* shall be required to be held in trust. The *Plan Sponsor* may, however, at its sole discretion, establish one or more trusts to hold such assets, and such trust(s) may or may not, as determined by the *Plan Sponsor*, contain such provisions as are necessary to qualify them for exemption from applicable federal, state, local, and other taxes.

Invalidity of Certain Provisions

In the event any provision of this *Plan* shall be held illegal or invalid for any reason, such illegality or invalidity shall not affect the remaining parts of this *Plan*, and this *Plan* shall be construed and enforced as if such illegal and invalid provisions had never been inserted herein.

Gender and Number

Pronouns and other similar words used in the masculine gender shall be read as the feminine gender where appropriate and the singular form of words shall be read as the plural where appropriate.

PLAN DEFINITIONS

Words you find in the body of the text that are *italicized* are defined in this section. The presence of the following definitions is not an indication that charges for particular care, supplies, or services are eligible for payment under the *Plan*; please refer to the appropriate sections of this Summary Plan Description for that information.

- ***accidental injury:*** an accidental physical *injury* to the body caused by unexpected means that does not arise out of or in the course of employment.

- ***actively at work:*** the *employee,* as hired by the *employer,* is working full-time and is paid regular earnings (temporary or seasonal employment is excluded) for a specified task or set of responsibilities. This includes:

  - working a specified number of hours each week on an annual basis, and
  - working at the *employer's* usual place of business or at a location to which your *employer's* business requires you to travel.

An *employee* who does not complete his or her work assignments due to leave of absence, strike, or layoff is not *actively at work.* Paid vacation days and holidays count as active work days if you were *actively at work* on your last regularly scheduled work date just prior to the vacation or holiday.

If an *employee* or eligible dependent is *hospital* confined (or confined in any other institution providing medical care, or receiving professional nursing care from a *home health care* agency, or otherwise *totally disabled*) on the date coverage would be effective, that *employee* or dependent will be considered to be *actively at work* for eligibility purposes of the *Plan*.

Once an *employee* terminates employment with the *Company,* the *employee* will cease to be considered *actively at work* and shall lose coverage under the *Plan,* regardless of whether the *employee* terminated employment due to a health factor or *disability.*

- ***ambulatory care center:*** any licensed public or private establishment that does not provide services or other accommodations for patients to stay overnight, but does provide:

  - an organized medical staff of *physicians*.
  - permanent facilities that are equipped and operated for the purpose of medical and/or surgical care.
  - continuous *physician* services and registered professional nursing services whenever a patient is in the facility.

- ***birthing center:*** a specialized facility that is primarily a place for delivery of a child following a normal, uncomplicated pregnancy and which fully meets one of the following two criteria: a) It is licensed by the regulatory authority having responsibility for the licensing of such facilities under the laws of the jurisdiction in which it is located; or b) If there is no state-licensing requirement for such facilities, it meets all of the following requirements:

  - It is operated and equipped in accordance with all applicable state laws;
  - It is equipped to perform routine diagnostic and laboratory examinations such as hematocrit and urinalysis for glucose, protein, bacteria, and specific gravity;
  - It has available to handle foreseeable *emergencies* trained personnel and necessary equipment, including, but not limited to, oxygen, positive pressure mask suction, intravenous equipment, equipment for maintaining infant temperature and ventilation, and blood expanders;

- It is operated under the full-time supervision of a *physician* or registered graduate nurse;
- It maintains a written agreement with at least one *hospital* in the area for immediate acceptance of patients who develop complications;
- It maintains an adequate medical record for each patient, containing prenatal history, prenatal examination, any laboratory or diagnostic tests, and a postpartum summary; and
- Subject to applicable law, it is normally expected to discharge or transfer patients within 24 hours following delivery.

- ***cardiac care unit:*** see *intensive care unit*.

- ***claims administrator:*** United Medical Resources, Inc. (*UMR*), the organization designated by the *employer* to administer claims to the *Plan*.

- ***Company:*** Lexington Precision Corporation.

- ***confinement:*** all periods of hospitalization of a *Plan participant* that result from the same or related causes. All periods of *hospital confinement* that result from the same or related causes are considered one period of *hospital confinement*, if the time from discharge to the readmission is within a 90-day period.

- ***cosmetic services:*** services designed to alter appearance without restoring function.

- ***covered charges:*** expenses or charges that are eligible for payment under the *Plan*.

- ***covered dependent:*** a *spouse* or *dependent child* who is eligible for coverage and enrolled under the *Plan*.

- ***creditable coverage:*** prior medical coverage of an individual under any of the following:
  - a group health plan.
  - health insurance coverage.
  - *Medicare* (Part A or Part B).
  - Medicaid, other than coverage consisting solely of benefits for distribution of pediatric vaccines.
  - Title 10 U.S.C. Chapter 55 (medical and dental care for members and certain former members of the uniformed services, and for their dependents).
  - a medical care program of the Indian Health Service or of a tribal organization.
  - a state health benefits risk pool.
  - certain other state-sponsored arrangements established primarily to provide medical benefits to persons who have difficulty in obtaining affordable coverage because of a medical condition.
  - a health plan offered under the Federal Employees Health Benefits Program.
  - a public health plan.
  - a health benefit plan under section 5(e) of the Peace Corps Act.

Creditable coverage will not include any days of the plan's waiting period. Similarly, in the case of a late enrollment under the *Plan* (whether as general late enrollment or under a special enrollment period), *creditable coverage* will not include days of the *Plan's* waiting period.

Days of *creditable coverage* that occur before a previous 63-day break in coverage are not counted. Accordingly, successive periods of *creditable coverage* from multiple plans will be counted as days of *creditable coverage*, provided that an intervening 63-day break in coverage did not occur between the *creditable coverages*. For example, assume prior to your *enrollment date* that you had 90 days of *creditable coverage*, then a 70-day break in coverage, then 120 days of *creditable coverage* ending on your *enrollment date*. In this case, only 120 days of *creditable coverage* will qualify as *creditable coverage* under the *Plan*. The preceding 90 days of *creditable coverage* will not qualify due to the previous 70-day break in coverage.

- ***custodial care:*** any type of service designed essentially to assist the recipient, whether *disabled* or not, in the activities of daily living. This would include, but not be limited to, bathing, dressing, toileting, cooking and feeding, house cleaning, transportation, and shopping. All services rendered by a home health aide are *custodial care*.

- ***dentist:*** a person currently licensed and duly qualified to practice dentistry.

- ***dependent child:*** any unmarried:

  - natural child of the *employee*, stepchild of the *employee,* legally adopted child (or legally placed child pending adoption) of the *employee,* or foster child, provided the child meets the dependency ruling by the IRS as found in Section 105 of the Internal Revenue Code and is a permanent resident of the United States;
  - child named in a divorce decree as being the responsibility of the *employee* for health benefits coverage; or
  - child named in a *Qualified Medical Child Support Order* as being the responsibility of the *employee* for health benefits coverage.

The *dependent child* must also be one of the following:

  - under 19 years of age (to the end of the day preceding his or her 19th birthday).
  - age 19-24 if the child meets the criteria of a *full-time student* as outlined in the **Eligibility of Full-Time Students** section.
  - a *disabled dependent child* age 19 or older as outlined in the **Eligibility for Disabled Children** section.

- ***disability (****or* ***disabled):*** the inability of an *employee* (because of *injury* or *illness*) to perform the material duties pertaining to his or her employment with the *employer*. *Disability* of a *covered dependent* is the inability (because of *injury* or *illness*) to perform all regular and customary activities usual for that *covered dependent's* age and family status. An *employee* or *covered dependent* is not considered to be suffering from a *disability* if he or she is performing any work or engaging in any occupation or employment for wage or profit, unless related to rehabilitation.

- ***disabled:*** see *disability*.

- ***durable medical equipment:*** equipment that is:

  - able to withstand repeated use,
  - primarily and customarily used to serve a medical purpose,
  - prescribed by a *physician*,

- not generally useful to a person in the absence of *illness* or *injury*, and
- provided solely for use by the patient.

- ***emergency:*** the sudden and unexpected onset of a *sickness* or *injury* with severe symptoms that requires immediate medical care. To be a medical *emergency*, the *sickness* or *injury*, as finally diagnosed or as indicated by its symptoms, must be one that would normally require immediate medical care, such as, but not limited to, acute appendicitis, asthmatic attack, kidney stone attack, stroke, heart attack, poisoning (including accidental overdoses), or convulsions. In order to determine whether a medical *emergency* exists, the following requirements will be applied:
  - Several symptoms must occur and the symptoms must be sufficiently severe to cause a person to seek immediate medical aid regardless of the hour of day or night;
  - Severe symptoms must occur suddenly and unexpectedly. A chronic condition in which moderately acute symptoms have existed over a period of time would not qualify for medical *emergency* consideration. However, if symptoms suddenly become severe enough to require immediate medical aid, it may, at that point, so qualify;
  - Immediate medical care is secured. A medical *emergency* would not be considered to exist if medical care is not secured immediately after the appearance of symptoms. A telephone call to a *physician* does not meet this requirement if deferred beyond 48 hours after the appearance of symptoms; and
  - The *sickness* or *injury* as finally diagnosed or as indicated by its symptoms and the degree of severity of the *sickness* or *injury* is such that immediate medical care would normally be required.

- ***emergency illness:*** a sudden and serious condition such that a *prudent layperson* could expect the patient's life would be jeopardized, the patient would suffer severe pain, or serious impairment of his or her bodily functions would result unless immediate medical care is rendered. Examples of an *emergency illness* may include, but are not limited to: chest pain; hemorrhaging; syncope; high fever; presence of a foreign body in the throat, eye, or internal cavity; or a severe allergic reaction.

- ***employee:*** an *employee* of Lexington Precision Corporation.

- ***employer:*** Lexington Precision Corporation, its subsidiaries, and the affiliated businesses that are designated by Lexington Precision Corporation as participating *employers* in the *Plan,* as well as any other businesses that are designated by Lexington Precision Corporation as participating *employers* in the *Plan*.

- ***enrollment date:*** the first day of coverage or, if the *Plan* has a waiting period, the first day of the waiting period. The *enrollment date* for a *late enrollee* or anyone who enrolls during a special enrollment period is considered to be the first date of coverage under this *Plan.*

- ***experimental (****or* ***investigational):*** a treatment is considered to be *experimental* or *investigational* if:
  - the treatment is governed by the United States Food and Drug Administration (FDA) and the FDA has not approved the treatment for the particular condition at the time the treatment is provided; or
  - the treatment is the subject of ongoing Phase I, II, or III clinical trials as defined by the National Institute of Health, the National Cancer Institute, or the FDA; or

- there is documentation in published U.S. peer-reviewed medical literature that states that further research, studies, or clinical trials are necessary to determine the safety, toxicity, or efficacy of the treatment.

- ***extended skilled nursing facility:*** an institution, or part of an institution, that meets all of the following criteria:
  - It is licensed pursuant to the law or approved by the appropriate authority.
  - It provides 24-hour nursing care and/or rehabilitation services for sick and injured patients on an inpatient basis.
  - It has nursing care and service policies developed with the advice of, and subject to review by, professional personnel.
  - It has a *physician*, a registered nurse, or other medical staff responsible for the execution of the aforementioned nursing care, and service policies developed with the advice of, and subject to review by, professional personnel.
  - It requires every patient to be under the care of a *physician*.
  - It makes a *physician* available to furnish medical care in case of an *emergency*.
  - It maintains clinical records on all patients, has appropriate methods for dispensing drugs and medicines, and has at least one registered nurse employed on a full-time basis.
  - It provides for a group of *physicians* to periodically review *medical necessity* for admissions, continuation of *confinements*, duration of stay, and adequacy of care.

The term *"extended skilled nursing facility"* does not include an institution that is primarily for intermediate or *custodial care*.

- ***family:*** the *employee* and each *covered dependent* who participates in the *Plan* because of his or her relationship to the *employee*.

- ***full-time student:*** a student enrolled for a number of hours or courses considered full-time by the accredited educational institution where he or she is in attendance.

- ***halfway house:*** a residential facility providing transitional care to patients between their discharge from the *hospital* or other treatment and their return to the community.

- ***home health care:*** see *home health services*.

- ***home health services:*** a program for care and treatment established and approved in writing, including an estimation of the duration of such program by the attending *physician,* together with such *physician's* certification that the proper treatment of the *injury* or *illness* would require *confinement* as a bed patient in a *hospital* in the absence of the services and supplies provided. Ongoing authorization is required and is based upon regular updates from the *home health care* agency or *provider*.

- ***hospice:*** a coordinated program of home, outpatient, and inpatient care for terminally ill patients with a prognosis of less than six months to live, operated by a licensed public agency or private organization, that provides all of the following:
  - nursing care by or under the supervision of a registered nurse.
  - medical social services under the direction of a *physician*.

- medical supplies, including drugs and biologicals and the use of medical appliances.
- *physicians'* services.
- short-term inpatient care, including both palliative care and *respite services* and procedures.

- ***hospital:*** an institution authorized to operate as a *hospital* by the state in which it is operating, engaged mainly in providing medical care and treatment of ill, pregnant, and injured persons on an inpatient basis for compensation, that meets the following criteria:
  - It is constituted, licensed, and operated in accordance with the laws of jurisdiction in which it is located (for example, *hospitals* in Ohio must be licensed according to Chapter 1739 of the Ohio Revised Code), or
  - It is accredited as a *hospital* by one of the following: a) the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); b) the American Osteopathic Hospital Association (AOHA); c) the American Osteopathic Association (AOA); or d) the Commission on Accreditation of Rehabilitative Facilities (CARF).
  - It is a *hospital,* a tuberculosis *hospital,* or a *mental health hospital,* as these terms are defined by *Medicare*, that is qualified to participate and eligible to receive payment under and in accordance with the provisions of *Medicare* (with the exception of a mental institution owned and operated by a state or political subdivision thereof).
  - It maintains on-premises diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment by or under the supervision of duly qualified *physicians.* (This does not apply to a mental institution.)
  - It continuously provides on-premises, 24-hour nursing service by or under the supervision of a registered nurse.
  - It is operated continuously with organized facilities for operative surgery on the premises. (This does not apply to a mental institution.)

The term *"hospital"* does not include a hotel, rest home, *extended skilled nursing facility*, *intermediate care facility*, nursing home, convalescent home, facility for *custodial care* of the mentally ill or of the aged, or an institution primarily for the treatment of drug addiction or alcoholism.

- ***illness:*** a mental or physical disease or infirmity, including pregnancy or pregnancy-related conditions, of a *Plan participant*.

- ***incur (****or* ***incurred):*** a *covered charge* is *incurred* on the date a service is rendered or a supply is obtained, unless otherwise specifically set forth in this SPD. With respect to a course of treatment or procedure that includes several steps or phases of treatment, *covered charges* are *incurred* for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, *covered charges* for the entire procedure or course of treatment are not *incurred* upon commencement of the first stage of the procedure or course of treatment.

- ***incurred:*** see *incur*.

- ***infertility:*** the inability to conceive naturally.

- ***initial enrollment date***: the earliest time during which an eligible *employee* may enroll under the *Plan*.

- ***injury:*** an accidental physical *injury* to the body caused by unexpected external means that does not arise out of or in the course of employment. All *injuries* sustained in connection with one accident are

considered to be one *injury*. The term *"injury"* does not include disease or infection, except pyogenic infection occurring through an accidental cut or wound.

- ***intensive care unit:*** a unit that accommodates critically or seriously ill or injured patients requiring constant audiovisual observation, specialized registered nursing and other nursing care, and special equipment or supplies immediately available on a standby basis, segregated from the rest of the *hospital* facilities. This includes *cardiac care units*.

- ***intermediate care facility:*** an institution recognized under and licensed under state law to provide, on a regular basis, health-related care and services to individuals who do not require the degree of care or treatment that a *hospital* or *extended skilled nursing facility* is designed to provide, but who, because of their mental or physical condition, require care and services (above the level of room and board) that can be made available to them only through institutional facilities. Public institutions for care of the mentally retarded or people with related conditions are also included.

- ***investigational:*** see *experimental.*

- ***late enrollee:*** an eligible *employee* or dependent who enrolls in the *Plan* other than on his or her *initial enrollment date* or during a special enrollment period.

- ***maintenance care:*** treatment provided for the sole purpose of preventing a decline of a medical condition and that does not result in improvement of the condition, but is rather intended to maintain a level of symptoms or severity of a condition. *Maintenance care* programs are those for which the patient can independently administer care and treatment to prevent the worsening of a condition.

- ***medical child support order:*** any judgment, decree, or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that:
  - provides for child support with respect to a *Plan participant's* child or directs the *Plan participant* to provide coverage under a health benefits plan pursuant to a state domestic relations law (including a community property law); or
  - enforces a law relating to medical child support described in Social Security Act §1908 (as added by the Omnibus Budget Reconciliation Act of 1993 §13822) with respect to a group health plan.

- ***medical necessity (****or* ***medically necessary):*** services, procedures, and supplies that:
  - are consistent with the symptom or the diagnosis and the treatment of an *illness* or *injury*,
  - are required for the prevention, diagnosis, cure, or treatment of a health-related condition, including services necessary to prevent a decremental change in either medical or *mental health* status,
  - are provided in accordance with generally accepted medical practice and professionally recognized standards,
  - provide care safely given at the appropriate level of service,
  - are not *experimental* services, *cosmetic services, maintenance care,* or *custodial care*, and
  - are not provided solely for the convenience of the *Plan participant* or the *provider.*

In determining questions of *medical necessity*, consideration is given to the customary practices of *providers* in the community where the service is provided. However, the fact that a *provider* may

prescribe, order, recommend, or approve a service or supply does not, of itself, make that service or supply *medically necessary*.

- ***medical services:*** professional services rendered by the attending *provider* that do not involve:
  - operative or cutting procedures for the treatment of disease or *injury*.
  - treatment of fractures, dislocations, and other *accidental injuries*.
  - obstetrical procedures, including prenatal and postnatal care.
- ***medically necessary:*** see *medical necessity*.
- ***Medicare:*** the health insurance program for the aged and *disabled* under Title XVIII of the Social Security Act, as amended.
- ***mental health:*** forms of *illness* including, but not limited to, bipolar affective disorder, schizophrenia, psychotic *illness,* manic depressive *illness,* depression and depressive disorders, anxiety and anxiety disorders, and any other mental or nervous condition classified in the Diagnostic and Statistical Manual (DSM). *Mental health* does not include any condition listed in Appendix G of the DSM-IV, titled "ICD-9-CM Codes for Selected General Medical Conditions and Medication Induced Disorders," or any comparable listing if Appendix G is no longer published.
- ***mental health treatment facility:*** a facility, or distinct part thereof, for the treatment of mental or nervous disorders, which meets all of the following criteria:
  - It is approved by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or it is a mental institution owned and operated by a state or political subdivision thereof.
  - It is primarily engaged in providing, at a charge to its patients, a program for diagnosis, evaluation, and effective treatment of mental or nervous disorders.
  - It is not primarily a school or a custodial, recreational, or training institution.
  - It provides all normal, infirmary-level *medical services* required during the treatment period, whether or not related to the mental or nervous disorder.
  - It provides, or has an agreement with, a *hospital* in the area to provide any other *medical services* that may be required.
  - It is under the continuous supervision of a psychiatrist who has the overall responsibility for coordinating patient care, and who is at the facility on a regularly scheduled basis.
  - It is staffed by *mental health physicians* who are directly involved in the treatment program, at least one of whom is present at all times during the treatment day.
  - It continuously provides the services of a *mental health* nurse and a *mental health social worker.*
  - It continuously provides skilled nursing services under the direction of a full-time registered nurse, with licensed nursing personnel on duty at all times.
  - It requires a written, individual treatment plan prepared and maintained for each patient based on a diagnostic assessment of the patient's medical, psychological, and social needs with documentation that the plan is under the supervision of a *mental health physician*.
  - It meets any applicable licensing standards established by the jurisdiction in which it is located.

- ***military service:*** uniformed services covered by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), which includes service in the Armed Forces, Army and Air National Guards, commissioned corps of the Public Health Service, Coast Guard, or any other category of service designated by the President of the United States.

- ***national medical support notice (****or* ***NMSN):*** a notice that contains the following information:

  - Name of an issuing state agency;
  - Name and mailing address (if any) of an *employee* who is a *Plan participant*;
  - Name and mailing address of one or more alternate recipients (e.g., the child or children of the *Plan participant* or the name and address of a substituted official or agency that has been substituted for the mailing address of the alternate recipient[s]); and
  - Identity of an underlying child support order.

- ***natural tooth (****or* ***natural teeth):*** a hard, bony appendage borne on the jaw.

- ***NMSN:*** see *national medical support notice*.

- ***non-participating pharmacy:*** any pharmacy licensed to dispense prescription drugs that is not included as a participant under the prescription drug program, offering pre-paid drug benefits to eligible *Plan participants*.

- ***participating pharmacy:*** any pharmacy licensed to dispense prescription drugs that is included as a participant under the prescription drug program, offering pre-paid drug benefits to eligible *Plan participants*.

- ***physician:*** any doctor of medicine (M.D.), osteopathy (D.O.), podiatry (D.P.M.), chiropractic (D.C.), dental surgery (D.D.S.), or medical dentistry (D.M.D.), duly qualified, currently licensed, and acting within the scope of his or her license at the time and place the service is rendered.

- ***Plan:*** the Lexington Precision Corporation Group Medical Care Plan.

- ***Plan Administrator:*** Lexington Precision Corporation.

- ***Plan Document:*** the legal document governing the administration and interpretation of the Lexington Precision Corporation Group Medical Care Plan.

- ***Plan participant:*** a covered *employee* or his or her *covered dependent*.

- ***Plan Sponsor:*** Lexington Precision Corporation.

- ***Plan Year:*** the 12-consecutive-month period that ends on December 31.

- ***pre-admission testing:*** outpatient X-ray and laboratory tests that meet each of the following criteria:

  - They are made within 5 days before surgery as a registered bed patient in a *hospital*.
  - They are for the same *injury* or *illness* causing the hospitalization of the *Plan participant*.
  - They are ordered by the same *physician* (or his or her *physician* consultant) who ordered the hospitalization.

- They are accepted by the *hospital* where hospitalization is to occur, in lieu of similar tests being made during hospitalization.

The term *"pre-admission testing"* includes outpatient X-rays and laboratory tests which would have satisfied all the tests set forth in this section, except that the expected hospitalization does not occur because of the results of such tests. The term *"pre-admission testing"* does not include tests for routine physical check-ups.

- ***pre-existing condition:*** a medical condition (whether physical or mental) of a *Plan participant*, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received, by or from a health care *provider* or practitioner duly licensed to provide such care under applicable state law and operating within the scope of practice authorized by such state law, within a specified time period prior to his or her *enrollment date*. Pregnancy is not considered a *pre-existing condition*. Genetic information will not be treated as a *pre-existing condition* in the absence of a diagnosis of the condition related to such information.

- ***provider:*** the person, institution, or other entity who or that provided the service or supplies on account of which payment may be due under this *Plan*. Each *provider* must be duly qualified, currently licensed, and acting within the scope of his or her license at the time and place the service is rendered. For this *Plan*, depending upon the services provided and the eligibility of benefits, a recognized *provider* may include, but may not be limited to, any of the following:

  - Advanced Registered Nurse Practitioner (ARNP)
  - Audiologist (MACCC-A)
  - Certified Chemical Dependency Counselor (CCDC)
  - Certified Nurse Midwife (CNM)
  - Certified Registered Nurse Anesthetist (CRNA)
  - Chiropractor (DC)
  - Doctor of Dental Medicine (DDM)
  - Doctor of Dental Surgery (DDS)
  - Doctor of Medical Dentistry (DMD)
  - Doctor of Medicine (MD)
  - Doctor of Optometry (OD)
  - Doctor of Osteopathy (DO)
  - Doctor of Podiatric Medicine (DPM)
  - Doctor of Psychology (PhD)
  - Licensed Clinical Social Worker (LCSW)
  - Licensed Family Counselor (LFC)
  - Licensed Independent Social Worker (LISW)
  - Licensed Occupational Therapist (LOT)
  - Licensed Physical Therapist (LPT)

- Licensed Practical Nurse (LPN)
- Licensed Professional Clinical Counselor (LPCC)
- Licensed Professional Counselor (LPC)
- Licensed Social Worker (LSW)
- Licensed Speech Therapist (MACCC-SLP)
- Master of Social Work (MSW)
- Medical Assistant (MA)
- Nurse Practitioner
- Physician's Assistant (PA)
- Registered Nurse (RN)
- Registered Physical Therapist (RPT)
- Surgical Physician's Assistant

- ***prudent layperson:*** a person with average knowledge of health and medicine who is not formally educated or specialized in the field of medicine.

- ***QMCSO:*** see *Qualified Medical Child Support Order*.

- ***qualified beneficiary:*** any individual covered by a group health plan on the day before a COBRA qualifying event. A *qualified beneficiary* may be an *employee*, an *employee's spouse,* or an *employee's dependent child.* A child who is born to or placed for adoption with the covered *employee* during a period of continuation coverage is considered a *qualified beneficiary*.

- ***Qualified Medical Child Support Order (****or* ***QMCSO):*** a *medical child support order* that creates or recognizes the existence of an alternate recipient's right to, or assigns to an alternate recipient the right to, receive benefits to which a *covered dependent* is entitled under this *Plan.* In order for such order to be a *QMCSO*, it must clearly specify the following:

  - The name and last known mailing address (if any) of the *Plan participant* and the name and mailing address of each such alternate recipient covered by the order;
  - A reasonable description of the type of coverage to be provided by the *Plan* to each alternate recipient, or the manner in which such type of coverage is to be determined;
  - The period of coverage to which the order pertains; and
  - The name of this *Plan.*

In addition, a *national medical support notice* shall be deemed a *QMCSO* if it:

- Contains the information set forth in the definition of *"national medical support notice"*;
- Identifies either the specific type of coverage or all available group health coverage. If the *employer* receives an *NMSN* that does not designate either specific type(s) of coverage or all available coverage, the *employer* and the *Plan Administrator* will assume that all are designated;
- Informs the *Plan Administrator* that, if a group health plan has multiple options and the participant is not enrolled, the issuing agency will make a selection after the *NMSN* is qualified,

and, if the agency does not respond within 20 days, the child will be enrolled under the *Plan's* default option (if any); and

- Specifies that the period of coverage may end for the alternate recipient(s) only when similarly situated dependents are no longer eligible for coverage under the terms of the *Plan,* or upon the occurrence of certain specified events.

However, such an order need not be recognized as "qualified" if it requires the *Plan* to provide any type or form of benefit, or any option, not otherwise provided to the *Plan participants,* except to the extent necessary to meet the requirements of a state law relating to *medical child support orders,* as described in Social Security Act §1908 (as added by the Omnibus Budget Reconciliation Act of 1993 §13822).

- ***rehabilitation facility:*** a facility that meets all of the following criteria:
  - A patient's condition must require the 24-hour availability of a *physician* to provide treatments that can only be provided in an in-*hospital* setting. This need should be verifiable by entries in the patient's medical record that reflect frequent and direct, *medically necessary physician* involvement in the patient's care.
  - The patient's condition must require 24-hour availability of a registered nurse with specialized training or experience in rehabilitation.
  - The patient must require an intense (at least 4 hours per day) level of physical and/or occupational therapy in addition to any other required therapies or services.
  - The patient must require a multidisciplinary team approach to the delivery of the program. This includes a *physician*, psychiatrist, rehabilitation nurse, *social worker,* and/or psychologist.
  - The patient's records must reflect evidence of a coordinated program, e.g., documentation that periodic team conferences were held with regularity.
  - The patient's records should reflect a realistic goal and significant improvement. Coverage stops when progress toward the established goal is unlikely, or when it can be achieved in a less intensive setting.

- ***residential care facility:*** an establishment that furnishes food and shelter to adult persons unrelated to the proprietor and may provide care and services beyond food, shelter, and laundry to any one or more such persons. This includes boarding homes for sheltered care and homes for the aged.

- ***respite services:*** short-term or intermittent care for persons with chronic or debilitating conditions that provides an interval of rest or relief to family members or caregivers who are responsible for those services on a day-to-day basis. Coverage of these services is included in any *hospice* benefit, limit, or exclusion.

- ***semi-private room:*** the charge made by a *hospital* for a room containing two or more beds.

- ***sickness:*** any *illness*, other than an *injury*, not covered by Workers' Compensation laws or any occupational disease law. The term *"sickness"* includes pregnancy.

- ***skilled nursing care:*** services that:
  - are deemed to be reasonable and *medically necessary,*
  - are provided by a registered nurse or a licensed practical nurse,
  - are under the direct supervision of a *physician,*

- include a plan of care established by a licensed *provider* and approved by the supervising *physician,* and
- are rendered intermittently to a patient who is homebound.

- ***skilled nursing facility:*** see *extended skilled nursing facility*.

- ***social worker:*** a properly licensed person holding the degree of Licensed Social Worker (LSW), Licensed Clinical Social Worker (LCSW), Licensed Independent Social Worker (LISW), Licensed Professional Clinical Counselor (LPCC), or Master of Social Work (MSW), legally qualified and licensed and acting within the scope of his or her license at the time and place the service is rendered.

- ***spouse:*** an *employee's* legally married husband or wife (not legally separated).

- ***substance abuse:*** dependence on, or abuse of, a chemical substance or alcohol as classified by the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM) or a comparable manual if the American Psychiatric Association stops publishing the DSM.

- ***substance abuse treatment facility:*** a facility for the treatment of alcoholism and drug abuse which meets all of the following criteria:
  - It is approved by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).
  - It is primarily engaged in providing, at a charge to its patients, a program for diagnosis, evaluation, and effective treatment of alcoholism and drug abuse.
  - It provides all medical detoxification services necessary in addition to its effective treatment program.
  - It provides all normal, infirmary-level *medical services* required during the treatment period, whether or not related to the alcoholism or drug abuse.
  - It provides, or has an agreement with, a *hospital* in the area to provide any other *medical services* that may be required.
  - At all times during the treatment period, it is under the supervision of a staff of *physicians* and provides skilled nursing services by licensed nursing personnel under the direction of a full-time registered nurse.
  - It prepares and maintains a written individual plan of treatment for each patient based upon a diagnostic assessment of the patient's medical, psychological, and social needs, with documentation that the plan is under the supervision of a *physician*.

- ***surgery center:*** any public or private establishment that meets the following criteria:
  - It has an organized medical staff of *physicians*.
  - It is a permanent facility equipped and operated primarily for the purpose of performing *surgical procedures.*
  - It provides continuous *physician* services and registered professional nursing services whenever a patient is in the facility.
  - It does not provide services or other accommodations for patients to stay overnight.

- It provides, or has an agreement with, a *hospital* in the area to provide any other *medical services* that may be required.

- ***surgical procedures:*** procedures limited to the following:
  - a cutting operation.
  - suturing of a wound.
  - treatment of a fracture.
  - reduction of a dislocation.
  - electrocauterization.
  - diagnostic and therapeutic endoscopic procedures.
  - injection treatment of hemorrhoids and varicose veins.
  - cardiac catheterization.

- ***total disability (****or* ***totally disabled):*** a person's complete inability to perform any and every duty of his or her occupation or any other work or employment for wage or profit, or his or her *covered dependent's* complete inability to perform the normal activities of a person of his or her age and sex in good health.

- ***totally disabled:*** see *total disability*.

- ***transplant (****or* ***transplanted*** *or* ***transplantation):*** the *transplant* of organs from human to human. For the purposes of determining eligible expenses under this policy, *transplant* includes only the following *transplants:* heart, heart and lung, lung (single or double), liver, kidney, pancreas, kidney and pancreas, human bone marrow, and stem cell *transplantation* and reinfusion. A *transplant* must be performed at a *transplant* facility (Center of Excellence) in order to be a covered item under the *Plan.* Skin and cornea *transplants* are not considered *transplants* under the *Plan* but are covered if *medically necessary*.

- ***transplantation:*** see *transplant*.

- ***transplanted:*** see *transplant*.

- ***UCR:*** see *usual, customary, and reasonable charges*.

- ***UMR:*** United Medical Resources, Inc., the *claims administrator*.

- ***usual, customary, and reasonable charges (****or* ***UCR):*** charges made for health care services or supplies essential to the care of the individual that are in accordance with each of the following:
  - the usual fee an individual *provider* most frequently accepts as payment for the same service within a geographic area for the majority of his or her patients for the procedure performed.
  - the customary fee, established by the *Plan,* to be the charge for the range of usual amounts charged and accepted by most *providers* of similar training and experience and in comparable geographical economic areas for the procedure performed.
  - the reasonable fee accepted as payment in light of all circumstances, including unusual circumstances involving medical complications or requiring additional time, skill, and experience.

The *Plan* uses industry-recognized sources to determine *UCR*.

Claims Administrator

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